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MEDICAID AND AFDC FRAUD AND ABUSE CONTROL AND RESTITUTION EFFORTS BY STATES AND LOCALITIES

"BEST PRACTICES" CASE STUDY: MICHIGAN MEDICAID PROGRAM

October 1976

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
MEDICAID BUREAU

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"Best Practices" Case Study

Michigan Medicaid Program

A Descriptive Review of Exemplary

Program Options

Prepared Under SRS Contract No. SRS-500-75-0004

by

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Health Care Financing Administration
Medicaid Bureau

Note: This report reflects the organization used in Michigan at the time of the study visit to Michigan. This organization was changed after the date of the visit.

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PREFACE

This report is one of a series of "best practices" case studies prepared by General Research Corporation and its subcontractor SysteMetrics under contract to the Office of Planning, Analysis and Evaluation, Social and Rehabilitation Service, Department of Health, Education and Welfare. These case studies are part of a larger effort by General Research Corporation and its subcontractor SysteMetrics to assist DHEW in the analysis of the fraud and abuse control activities nationwide in Medicaid and Aid to Families with Dependent Children programs. Other activities include a nationwide mail survey to collect baseline data on fraud and abuse control efforts in all states and an analysis of the options available to the Federal government to further enhance fraud and abuse control in these programs.

The "best practices" case studies are based on visits made by GRC/SysteMetrics staff to selected states which appeared to constitute the best examples of fraud and abuse control programs. The primary objective of this effort is to determine what procedures and practices that the selected states are using appear to be effective and worthy of replication in other jurisdictions. Each state is individually reported in this case study format and from this data base a final analytic report discussing the relative value of the exemplary practices seen in all states will be prepared. The states to be reported in this series include:

Medicaid	AFDC
California	Maryland
Maryland	Massachusetts
Massachusetts	Michigan
Michigan	Minnesota
New Jersey	New Jersey
Ohio	Ohio
Oklahoma	Pennsylvania
Pennsylvania	Washington
Washington	Wisconsin

The states were selected in conjunction with DHEW personnel and represent those states which appeared to represent a mix of practices of interest to the study and which were suitable for site visits at the time of the study. Therefore, these do not necessarily represent the "best" nine states with respect to fraud and abuse control in each program but are certainly among the best.

Fraud and abuse control is an integral part of maintaining program integrity and increasing the quality and efficiency with which the program is administered and program goals are achieved. It is essential that fraud and abuse control procedures not be viewed in isolation from other program elements, but should be recognized as being part of a series of steps which states can take to improve the operation of their programs and reduce costs incurred through the misappropriation of program funds. Therefore, in the course of conducting this study and in developing the case study reports, fraud and abuse control efforts have been defined to include all systems and procedures which impact fraud and abuse prevention, detection, investigation, administrative actions, prosecutions and recovery. The case studies are organized to report each state's activities in these functional areas in the initial chapters. The authors' opinions and analysis have been reserved for the final chapter on best practices. The best practices chapter is designed to discuss conceptually how and why procedures reported in the initial chapters are exemplary and may be suitable for replication in other jurisdictions. Therefore, the best practices chapter discusses the pros and cons of such practices in various settings and is not directly a comment on the state reported, but rather an analysis of the practice per se and how the reported state exemplifies the concept.

Finally, these reports are in no way intended to be evaluations of the states involved and General Research Corporation is deeply indebted to the states which so graciously participated and assisted in these studies through the contribution of their time, information, and ideas.

ACKNOWLEDGMENT

General Research Corporation and the author wish to thank the staff of the Michigan Department of Social Services and the Michigan Department of Public Health, who so generously shared their time and experience to assist in this study. We especially wish to thank Mr. John Neidow of MDSS and his staff, whose exemplary work puts meaning into the words "program integrity."

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I. PROGRAM OVERVIEW

A. Program History and Characteristics

The Michigan Title XIX program was established in 1967, shortly after the passage of the Federal Medical Assistance Program amendments to the Social Security Act that created Medicaid. Starting with initial expenditures of approximately $60 million, the program has increased in size by a factor of 10. It now ranks as the fourth largest in the nation, and in fiscal year 1975 the program spent approximately $615 million for delivery of medical services to over 830,000 individuals. Michigan has a very comprehensive package of Medicaid benefits and covers both categorically eligible and medically needy persons.

The Michigan Medicaid program is run by the Department of Social Services, which is the designated Single State Agency. Important functions are also performed by the Department of Public Health, which is an administratively separate government agency. The State claims to spend less than 1% of total benefits payments on administrative costs; this compares very favorably with the overall average of 4.3% for the Medicaid program nationwide.

One unusual feature of the Michigan Medicaid program is that the State acts as its own fiscal agent (i.e., pays the claims itself). This was not always the case. The program originally contracted with Michigan Blue Cross/Blue Shield. In 1969, however, the State conducted a study of its Medicaid program which led to the conclusion that the claims processing function could be done better and cheaper if it were brought in-house.[1] A system was designed during 1970-1971 and implemented in 1972

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[1] In Congressional testimony in the fall of 1975, Paul Allen, Chief Deputy Director of DSS estimated that administrative costs of the program had been reduced 30% since the state had taken over the Claims Processing Section.

and the Blues were essentially phased out by March 1973. (Blue Cross still performs institutional cost audits for the state.) It was the opinion of several DSS and DPH persons that the internalization of the claims processing function contributed significantly to better control of provider fraud and abuse.

B. Overview of Administration

The Michigan Department of Social Services is the designated single state agency responsible for administration of the Medicaid program. DSS administers the program through the Bureau of Medical Assistance. The surveillance and utilization review function is delegated, through a cooperative agreement, to the Department of Public Health, which is the only other agency with significant responsibilities related to fraud and abuse control in the Medicaid program.

Exhibit I-1 presents a functional organization chart of the Department of Social Services and Department of Public Health offices which have responsibilities relating to fraud and abuse control. The two offices most directly involved are DSS/Medicaid Investigation Section and DPH/Medicaid Monitoring Section. The Office of Standards and Investigations, within which the Welfare Inspector General is located, is responsible for investigating AFDC recipient and agency fraud.

One unique administrative aspect of the Michigan Medicaid administration structure is that claims rocessing is part of the Bureau of Medical Assistance. This differs from some other states where data processing services is in a support organization and not directly under the control of the primary Medicaid program director. In DSS each program office has its own computer support staff responsible for interfacing with the Department's computer operations staff. Therefore, each program director has control of the computer systems which support his program area. Invoice processing is discussed further in the prevention and detection sections of this report.

The Attorney General's office has an Assistant Attorney General assigned to DSS matters. In Michigan the Attorney General handles civil matters for the state and local county prosecutors handle all criminal cases.

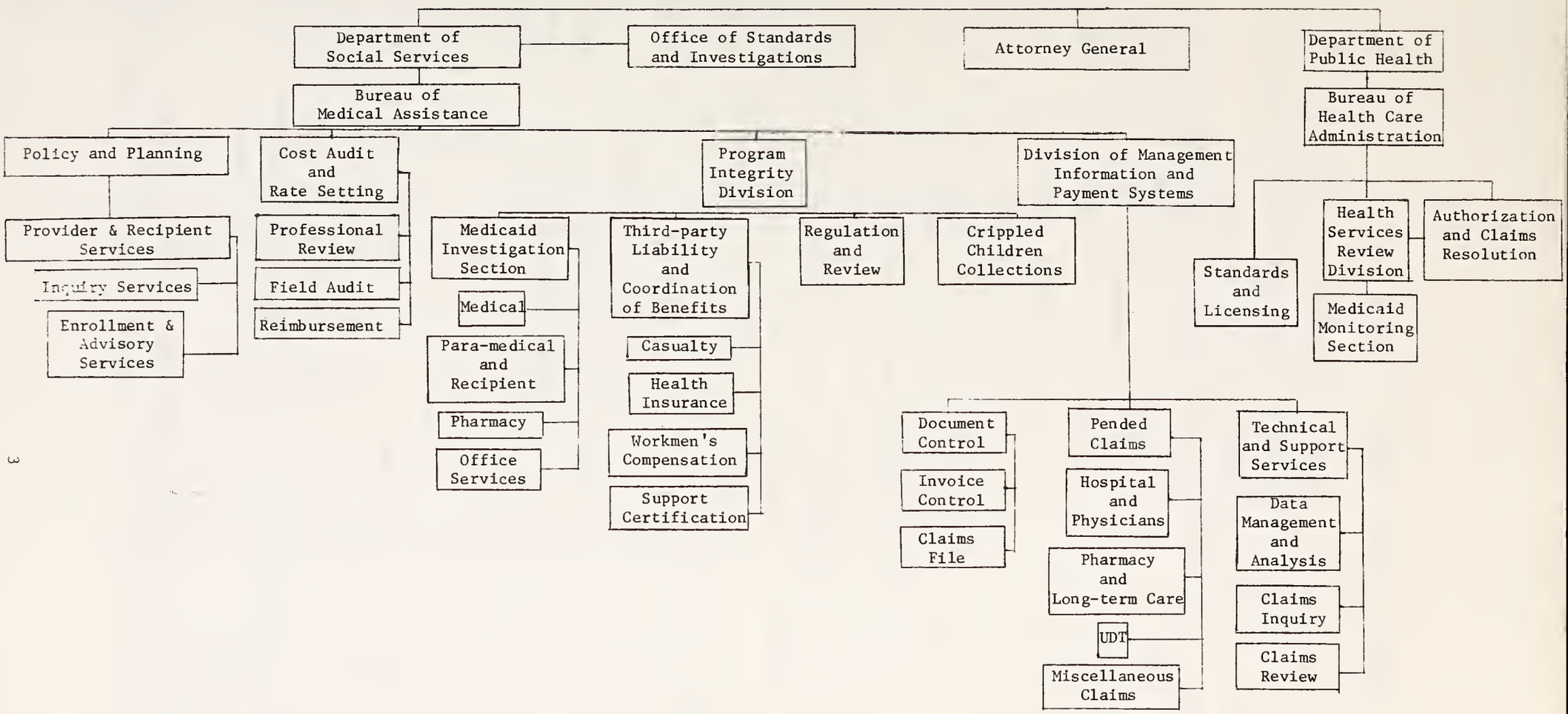


Figure I-1—Functional Organization Chart of Executive Departments Showing Units Contributing to Medicaid Provider Fraud and Abuse Control in Michigan

II. PROVIDER FRAUD AND ABUSE CONTROL PROGRAM

A. Administration

There are two key agencies involved in administering provider fraud and abuse control. These are the DSS/Medical Investigation Section and the DPH/Medicaid Monitoring Section.

Exhibit II-1 presents the organization of the DSS/Medicaid Investigation Section. In early August, 1976 this unit received authorization for an additional 20 staff members to enlarge the total unit to 49 employees. As shown, there are three teams each headed by a supervisory investigator with each team specializing in certain provider categories. In fiscal year 1976 the total budget for this unit was $470,000. The background of staff is a mixture of law enforcement and ancillary health care delivery experience: pharmacy operations, laboratory technician, etc. Two of the senior investigators were previously associated with police agencies, and the pharmacy unit chief is a pharmacist. Michigan follows the pattern found in other states of having a pharmacist who demonstrates significant talent for investigation. The unit chief estimates that approximately six months on-the-job training is required for new staff prior to full independent work. All staff are based in the Lansing office; the bulk of the work outside of Lansing requires staff travel to Wayne County (Detroit). Relatively little staff time is spent in other parts of the state. Procedurally, the Medicaid Investigation Section deals with fraud and abuse as it relates to non-medical violations of program regulations and legislation, such as prescription splitting, substituting generics for brand names, billing for services not provided, etc. The Medicaid Monitoring Section of the Department of Public Health is responsible for the medically related issues of overutilization, quality of care, etc.

Philosophically, Michigan has been a non-prosecution oriented state with the fraud and abuse control efforts focused on suspension and recoupment. In cases of recoupment (and in the infrequent prosecutions) the policy has been to encourage the widest possible publicity because of its deterrent effect.

The other unit primarily involved in the administration of fraud and abuse control activities is the Department of Health's Medicaid Monitoring

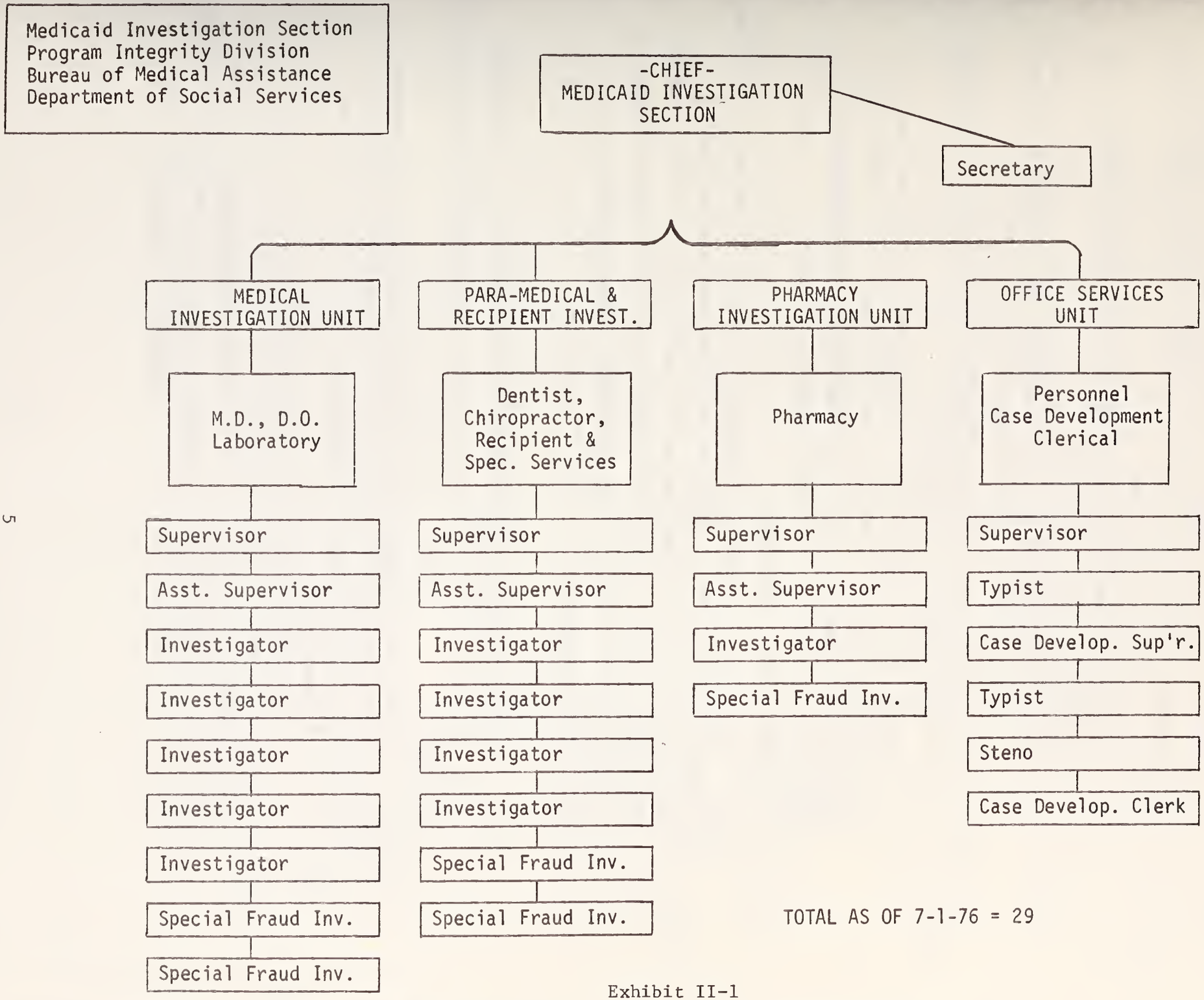


Exhibit II-1

Organization of the Medicaid Investigation Section

Section (MMS). This unit primarily conducts the Medicaid surveillance and utilization review function and is concerned with questionable medical practices. Such practices include:

- medical necessity—was the care provided really required by the patient? (overutilization)
- billing practices—were the services rendered properly billed? (billing multiple surgical procedures when a single procedure code includes all procedures at less cost, etc.)
- quality of care—does the pattern of practice suggest inappropriate services or other questions about the quality of services being provided to recipients?

There are approximately 80 staff positions in the Division of Health Services Review, the majority of which are devoted to Medicaid Monitoring. Professional staff are primarily health analysts, primary and ancillary health care providers (physicians, nurses, etc.), and statisticians or data technicians.

Michigan officials are well aware that coordination and cooperation between DSS/Medicaid Investigations and DPH/Medicaid Monitoring has not been optimal and to some degree the fraud and abuse control program is fragmented. The relationship of the two units is further discussed in the subsequent sections which functionally describe the fraud and abuse control activities.

B. Prevention

Although DSS/MIS and DPH/MMS are the primary actors in fraud and abuse control, there are 3 other units which have prevention responsibilities. These are:

DSS/Bureau of Medical Assistance/Policy and Planning/Provider and Recipient Services (provider enrollment and education)

DSS/Bureau of Medical Assistance/Management Information and Payment Systems

DPH/Bureau of Health Care Administration (licensing, prior authorizations, and prepayment claims review)

DSS/BuMA/Division of Policy and Planning/Provider and Recipient Services

This unit conducts two activities which can be described as preventiv First, it is this unit that "enrolls" providers in the program. The

enrollment process involves verifying with the health department licensing agency that the provider is authorized to practice in Michigan, verifying the providers' specialties or verifying that the provider meets the conditions of participation. More importantly, this unit operates a provider education program which holds throughout the state approximately 250 provider seminars a year, in billing procedures, program requirements, and program regulations. In addition, this unit arranges for speakers for professional and other groups upon request.

The second activity performed by Provider and Recipient Services is Inquiry Services. The unit operates a telephone hot-line which providers can use to receive answers to their questions. To the extent that this service prevents misbillings, it prevents abusive practices.

DSS/BuMa/Division of Management Information and Payment Systems

As noted previously, Michigan took over claims processing from Michigan Blue Cross/Blue Shield in 1972 after it was determined it was in the state's interest to perform the function internally. This capability materially aided the State in implementation of the MMIS. Michigan received certification for its Medicaid Management Information System (MMIS) in January 1976 and as of June 1976 was one of only eight states to have a certified system. The operation of the MMIS is the responsibility of the Division of Management Information and Payment Systems of the Bureau of Medical Affairs (BuMA).

The MMIS actually assists fraud and abuse control in three functional areas:

- prevention through "front-end" edits of claims and denial or suspension of questionable claims;
- detection through automatic suspension of certain specified claims (e.g., providers under investigation) and generation of subsystem output reports (e.g., provider profiles, etc.)
- investigation through generation of specialized reports used in investigation (i.e., claims histories).

The latter two functions will be discussed in subsequent sections of this report.

The prevention function lies primarily in the front-end edit and suspension capability.

- The MMIS can be instructed to suspend claims prior to payment such as claims from providers under review or on probation or claims for certain types of services which are prone to abuse;
- Standard edits suspend for both technicalities (claim incorrectly filled out) and for content (inpatient lengths of stay that exceed norms)

Pended claims are: (1) reviewed by invoice processing and technical error corrected; (2) sent to Department of Health/Authorization and Claims Resolution Section for review of medical question; and/or (3) paid or returned to provider with explanation of the problem.

Ninety percent of all claims are paid within 30 days and those that are suspended are acted upon within an only slightly longer period of time.

The prevention function is conducted through the interaction of three MMIS subsystems:

- Client Information System (CIS)—This "recipient subsystem" maintains the identification of all recipients eligible for Medicaid;
- Provider Enrollment (PE)—This "provider subsystem" maintains records of all participating providers; and
- Invoice Processing (IP)—This is a combination of the standard MMIS Claims Processing and Reference File Subsystems. This subsystem processes claims by verifying the eligibility of the recipient and the participation of the provider through the previously listed subsystems and applying other appropriate "front-end" edits including Medicaid practitioner usual and customery charge data. It also generates various lists of claims suspended due to errors and creates the paid claims data base used for report generation by other subsystems.

Exhibit II-2 presents a diagram of the MMIS as it functions in Mighican.

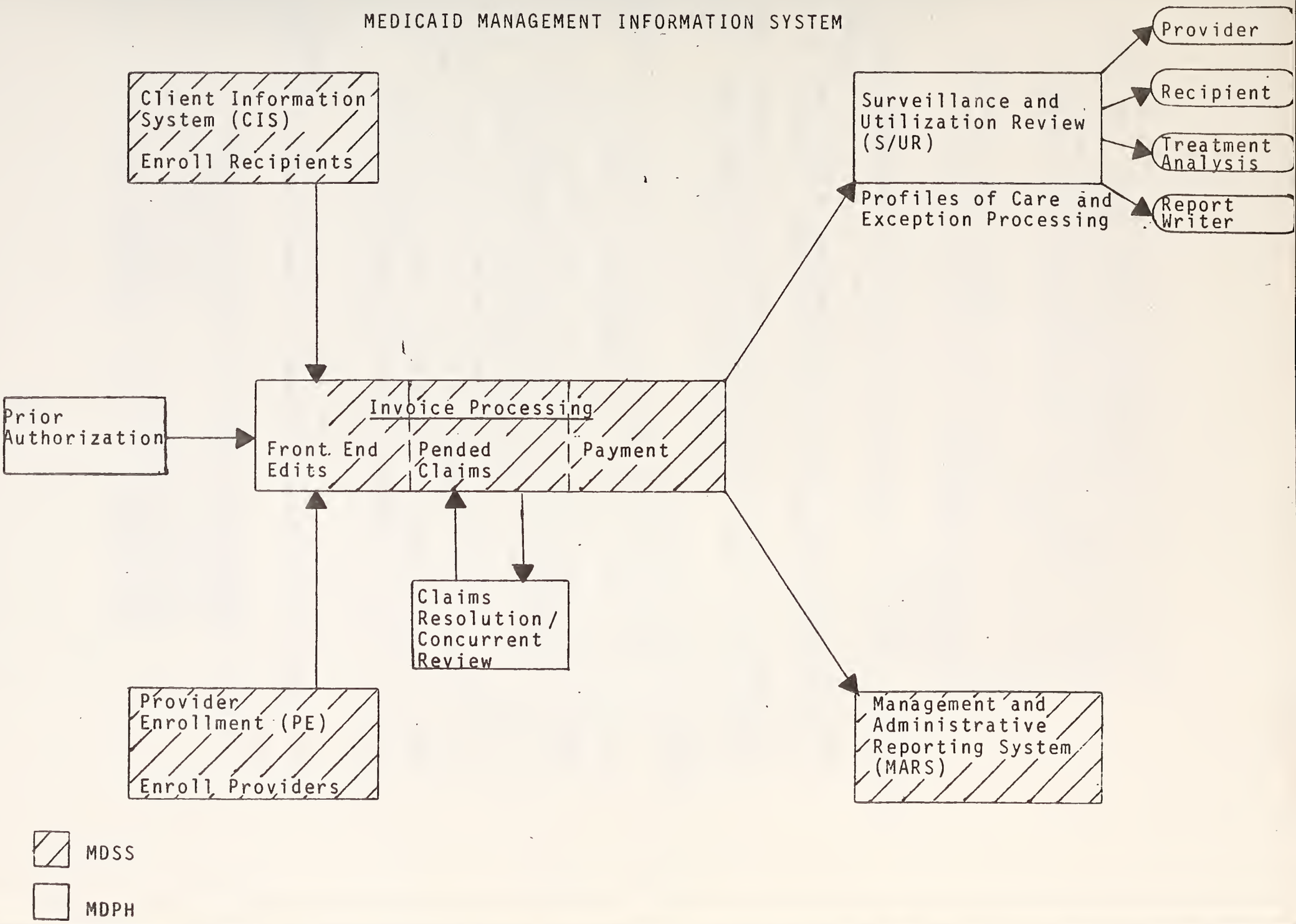
Department of Public Health/Bureau of Health Care Administration

The DPH/Bureau of Health Care Administration is also active in Prevention. Two of its divisions play a role. These are:

Division of Standards and Licensing. This unit is responsible for licensing providers in the State and providing information to the Medicaid program as to the status of practitioners' licenses.

Exhibit II-2

MEDICAID MANAGEMENT INFORMATION SYSTEM



Division of Authorization and Claims Resolution. This division is responsible for reviewing requests and providing prior authorizations for specified services. Such services include: dental, physical therapy, occupational therapy, prosthetic devices, inhalation therapy, etc. Prior authorizations are designed to prevent overutilization of selected services which are costly and/or prone to abuse.

This unit is also responsible for prepayment review of claims which have been suspended by the claims processing system and involve medical questions.

C. Detection

Exhibit II-3 presents the primary sources of fraud and abuse detection information. The two offices which use this information and are responsible for the detection function are Department of Public Health/ Medicaid Monitoring Section and Department of Social Services/Medicaid Investigations. This section of this report is organized in terms of the ways these two units use the available information and conduct their detection functions.

DPH/Medicaid Monitoring Section

The Medicaid Monitoring Office conducts the Medicaid surveillance and utilization review function. The staff is made up primarily of individuals with backgrounds in health care. Their primary detection tool is the MMIS output reports. If their detection activities result in "cases" involving health care issues, they handle the case within the Section. Identified cases which involve apparent violation of non-medical program regulations (prescription splitting) or apparent fraud (double billing) are referred to the Medicaid Investigations Unit.

Exhibit II-4 presents an overview prepared by Michigan to describe its surveillance and utilization review subsystem.

The system is currently operational for physicians' services. Other categories of service are projected to go operational on the following schedule.

clinical laboratories	October 1976
pharmacies	November 1976
inpatient hospital	January 1977
outpatient hospital	April 1977
long-term care	April 1977
dental services	September 1977

Exhibit II-4

OVERVIEW: SURVEILLANCE AND UTILIZATION REVIEW

PRIMARY SOURCES OF FRAUD/ABUSE DETECTION INFORMATION

Internal

1. High dollar volume providers (in relationship to the provider universe). Generated by invoice processing system.

2. Unusual patterns of care or profits that are unusual. Generated by invoice processing system and analyzed by Medicaid Monitoring against implicit and explicit criteria.

3. Providers on probation.

4. Return of Explanation of Benefits form from recipients. (This has recently been discontinued.)

5. Referrals from other state agencies -- Inspector General, Public Health Department field staff, Department of Licensing and Regulation, CARS Division, Third Party Liability Section, and various state law enforcement agencies.

6. Referrals from Medicare intermediaries and carriers (seldom).

7. Providers supplying services of special interest at any point in time -- abortions, hearing aids, etc. This is a kind of "issue of the month" procedure.

External

1. "Hot Line" for telephoned complaints or allegations.

2. Written complaints from recipients. Departmental policy is to promote such complaints through news releases and advertising.

3. Provider complaints.

4. Consumer, citizen, and patient/welfare rights groups.

Exhibit II-4

OVERVIEW: SURVEILLANCE AND UTILIZATION REVIEW

The Surveillance and Utilization Review Subsystem (S/UR) has been developed to accomplish the following primary objectives:

I. Develops, over time, a comprehensive statistical profile of health care delivery and utilization patterns established by provider and recipient participants in the various categories of service authorized under the Medicaid Program.

II. Provides information which will reveal, and facilitate investigation of potential defects in the level of care or quality of service, potential misutilization and promotes corrective action of individual participants of the Medical Assistance Program.

III. Accomplishes the substantive objectives stated above with a minimum level of manual clerical effort with the efficient use of analytic & professional medical expertise and with a maximum level of flexibility with respect to management objectives.

The basic approach employed by S/UR in achieving its stated objectives is the technique of exception reporting. Within the context of the Medicaid program, exception reporting involves the following major functions:

I. Maintains such data on the activities and characteristics of individual Medicaid participants as may be obtained from paid claims and from provider and recipient enrollment procedures.

II. Classifies participants into peer groups according to demographic, medical and utilization characteristics.

III. Develops a statistical profile of each peer group classification to be used as a base line for evaluation.

IV. Develops a statistical profile, compatible with the peer group profile, of each individual participant.

V. Automatically compares each individual participant profile to the appropriate group profile.

VI. Reports, as suspected misutilizers, all individual participants who deviate significantly from their group norm or from predetermined standards.

The S/UR Subsystem, as implemented in Michigan, is designed to accomplish the required exception reporting functions through six (6) main modules or processes. These modules are the Provider Module, the Recipient Module, the Treatment Analysis Module, Report Writer Modules, Interface Module and the Control Module.

The Provider and Recipient Modules produce, through exception processing, the following reports:

I. Management Summary Reports present a statistical profile on each of the peer group classifications defined by the user. The content of these reports corresponds to that of the Summary Profile and Treatment Analysis Reports described below. These reports communicate to the user the group norms developed by the system, and assist in whatever modifications may be required to tailor these norms for controlling production volumes and other management needs.

II. Summary Profile Reports present, for each individual Medicaid participant, an interrelated set of statistical report items which have been carefully selected to reveal common types of misutilization, subject to detection by statistical reporting techniques. Data on these reports are presented in such a manner that long term trends in utilization patterns are easily recognized without compromising the need to recognize potential misutilization at the soonest possible moment.

III. Claims Detail Reports support the investigation of misutilization by individual participants. These reports permit a high level of user selectivity in displaying essential data from each adjudicated claim.

In addition to the above reports generated from the provider and Recipient Modules, the Treatment Analysis and Special Report Writer Modules produce:

I. Treatment Analysis Reports which facilitate an analysis of the level and quality of care rendered by individual providers of physician and inpatient hospital services. Data on these reports are organized to show specific services rendered in response to specific diagnoses.

II. Special Reports which are requested from the system. The content and format of these reports is specified by the user. Any data contained in a computer file of adjudicated claims may be selected and printed, in order to satisfy requirements for information not met by the standard reports mentioned above or to test report formats before incurring the expense of having them written in hard coded programs.

This schedule is subject to change due to the conversion of the S/UR subsystem from the State's health and welfare data center to the engineering and technical data center. This change (which involves conversion from Honeywell equipment to Burroughs equipment) reflects priority being given to the system through the transfer to a less busy data center.

On the category of service which is operational, experimentation is being conducted concerning the exception criteria (standard deviation from group average vs. absolute values). The unit director estimates that staff can review approximately 2000 exceptions per quarter and the experimentation with the exception criteria is to determine on what basis the most useful exceptions are generated.

DSS/Medicaid Investigations Section

This unit appears to rely primarily on traditional police sources such as complaints (internal and external) and not in any primary way on detection through claims screening. The detection function conducted through analysis of computer generated reports is primarily conducted by the Medicaid Monitoring Section, as discussed above. To date this detection procedure has resulted in relatively few cases being referred to Medicaid Investigations. Michigan officials recognize that the program is fragmented with regard to the relationship of Medicaid Monitoring and Medicaid Investigations and the flow of information from Monitoring detection activities to Investigations. Over the last year steps have been taken to attempt to better coordinate these two units' activities. This will become an even more important issue as the S/UR subsystem becomes fully operational and the capability for Medicaid Monitoring to detect major schemes and valid fraud cases is increased.

In addition to the relatively few cases referred by Medicaid Monitoring, the other significant source of cases is the Cost Audit and Rate Setting staff of DSS, which detect irregularities in institutions which suggest the need for an investigation.

Although the MMIS has the capability to generate explanations of Medicaid benefits (EOMBs), the Medicaid investigations unit had an unfavorable experience with the use of EOMBs as a detection technique.

Investigation personnel favored the technique as a method for generating complaints, but the response to the first mailing was so great that the available personnel were unable to review the responses and make determinations as to which warranted investigations. This fact appears in large part to result from the confusing nature of the forms which were mailed out.

The detection method used most frequently internally in investigations is review of claims from high dollar providers or spot checking of providers who have previously been under suspicion or investigation. Medicaid investigations estimate that 160 physicians (2% of all physician providers) collect approximately 25% of the fees paid out for physician services. Therefore, in the last year Investigations has been concentrating on these providers.

Whether based on an internal detection criteria (high dollar provider) or a complaint from another source, the standard detection activity which would transform an allegation or suspicion into a "case" for investigation is a review of a sample of claims. Ordinarily this would involve a random selection of approximately 50-100 claims to see if a pattern of fraud or abuse appears to exist. Of course, if the case was referred by Medicaid Monitoring or another agency source, the problem might already be specified through the other agency's activities and would immediately become a "case" for investigation.

D. Investigation

There are two units which conduct "investigations" with respect to fraud and abuse.

- Department of Public Health/Medicaid Monitoring
- Department of Social Services/Medicaid Investigations

The Medicaid Monitoring unit performs the surveillance and utilization review function and is staffed by health analysts and statisticians. This unit does not perceive itself as an "investigations" unit. It is primarily involved in monitoring the level, necessity, and quality of care provided to program recipients. It identifies apparent problem areas through use of the S/UR subsystem reports and works with providers

to resolve these problems and improve services to recipients. In the course of this monitoring it may be necessary to visit a provider's office, hold an informal conference with the provider, discuss the problem with a peer review group, etc. However, when cases involve fraud or abuse of the program, the case is referred to Medicaid Investigations in DSS.

The DSS Medicaid Investigations Section staff primarily are ex-law enforcement officials or ancillary health providers who have been trained in investigations (pharmacist, laboratory technician, etc.). The unit is "investigation" oriented in the traditional police sense and philosophically oriented toward recoupment of funds.

Situations which could suggest the possible existence of fraud and about which this unit is concerned include:

1. Billings for services, supplies or equipment which were not rendered to, or used for Medicaid patients;
2. Billings for supplies or equipment which are clearly unsuitable for the patient's needs or are so lacking in quality or sufficience for the purpose as to be virtually worthless;
3. Flagrant and persistent overutilization of medical or para-medical services with little or no regard for results, the patient's ailments, condition, medical needs or the doctor's orders;
4. Claiming of costs for noncovered or nonchargeable services, supplies, or equipment disguised as covered items;
5. Material misrepresentations of dates and descriptions of services rendered, or of the identity of the recipient or the individual who rendered the services;
6. Duplicate billing which appears to be deliberate. This includes billing the Medicaid program twice for the same services;
7. Arrangements by providers with employees, independent contractors, suppliers and others which appear to be designed primarily to overcharge the Medicaid program with various devices (commissions, fee splittings) used to siphon off or conceal illegal payments;
8. Charging to the Medicaid program, by subterfuge, costs not incurred or which were attributable to nonprogram activities, other enterprises or personal expenses.

As shown in the organization chart, previously referenced as Exhibit I-1, the Medicaid Investigations staff is organized into three units (medical, para-medical and recipient, and pharmacy) and cases are assigned to the appropriate unit based on provder type.

Exhibit II-5 is a description supplied by DSS of the usual procedures used by the staff of the Medicaid Investigation Section for various types of providers.

In addition to the investigation procedures described in Exhibit II-5, Investigations staff "shop" providers, as appropriate, posing both as Medicaid recipients, with card, and as cash customers. Exhibit II-6, also prepared by BuMA, describes the purposes for which shopping of various types of providers is used. It should be noted that Investigations uses "shopping" in a controlled manner within specified procedures. An entire fictitious case is established in the Client Information System and a regular Medicaid Card is generated for the shopper. Thus, if a provider makes an inquiry, a clerk following routine procedure would be able to verify from the CIS data base that the card is valid. Medicaid Investigations is very careful to assure that the provider does not know he has been "shopped" so that claims are submitted that can be contrasted to the shopper's testimony or the record.

Although a case may be dropped at any point during the investigation, most investigations proceed through all the steps with the final determinations being made only after the investigation is complete. As noted previously and as can be seen from the previous exhibits, Investigations are primarily oriented toward documenting overpayments and recovering funds.

Michigan investigators use a great deal of normal police procedure to assure that a complete and uncontaminated chain of evidence exists. This includes verifying appointments with providers by letter, always having two staff members present during discussions with providers to provide a witness later, if required, photocopying all necessary records, etc.

In order to understand the Michigan Medicaid Investigations Section, it is necessary to understand the Section's strong procedural

Exhibit II-5

PROCEDURES FOLLOWED BY MEDICAID INVESTIGATIONS SECTION PERSONNEL

A. Practitioner (M.D., D.O.), also Chiropractor, Podiatrist

1. The "in-house" review of samplings of physicians' and/or recipients' billings history prior to the actual field claims review to

   a. Establish billing trends,
   b. Establish possible areas of abuse or overutilization,
   c. Look for double billings for services, etc.

2. Verification that services were received by direct contact with the recipient.

3. Verification of claims by review of medical records at the physician's office. This involves the actual review of medical records, the complaint, diagnosis, history, dispensing record and treatment record. It also includes the actual review of laboratory results, EKG results, various specialized tests, x-rays, etc.

4. Establishment of usual and customary. This is to establish the normal charges to cash-paying customers and to verify that the Medicaid Program is not charged above the usual and customary charge by the practitioner.

5. The observation of billing and treatment practices which include "recalls" or call-backs of recipients in order to generate extra professional fees as well as "nonmedically necessary" treatments or procedures billed for. In this particular area of questionable medical necessity, if and/or when it becomes necessary for peer-review, this area is referred to physician review and is then returned to the Section for final analysis and refund calculation, if any.

6. Development of cases of kick-backs or collusion between providers, if found or indicated.

B. Pharmacy

1. Establishment of usual and customary charges to the public to ascertain that the Medicaid Program is not billed above the pharmacy's usual charges.

2. The establishment of true acquisition cost of drugs billed the program. The program requires the passing on to the program of all discounts received in excess of 2%.

3. Verifying through pharmacy and computer records the presence, if any, of

   a. Double billings
   b. "Add-on" or fraudulent billings
   c. Prescription splitting—the generation of extra prescriptions by only partially filling the original prescription, or, in the case of nursing home supplying pharmacies, the generation of prescriptions on less than a 30-day basis, thus generating extra professional fees to the program.

4. Verification of authenticity of prescriptions with physicians.

5. Verification of actual drug dispensed in comparison to the drug prescribed (i.e., substitution of lower-priced generic equivalent drugs while billing the program for higher-priced trade-name drugs).

6. Development of cases of kick-backs or collusion between providers, if found or indicated.

C. Ambulance

1. Verification with physicians of the "medical necessity" of all return trips from a hospital or other institutional setting (basically not allowed service).

2. Verification of mileage billed for.

3. Review for double billings.

4. Verification that services were performed.

5. Verification of special services billed for:

   a. Oxygen or resuscitation.
   b. Emergency run.
   c. Night run.

6. Development of cases of kick-backs or collusion between providers, if found or indicated.

D. Laboratory

1. Verification of usual and customary.

2. Establishment of equipment and instrumentation of the laboratory and verification if the program was billed for higher priced individual tests while performed by lower-cost automated equipment.

3. Verification of physician's order for laboratory work—laboratory findings.

4. Verification that services were performed.

5. Development of cases of kick-backs or collusion between providers, if found or indicated.

Exhibit II-5 (continued)

E. Special Services (Optometrists, Opticians, Hearing Aid Dealers, Methadone Clinics, Shoe Suppliers, Oxygen Suppliers, Medical Supplies Providers, etc.)

All of the above procedures which relate to these providers.

F. Dentist

All of the above procedures which relate to these providers in addition to the special requirements of the dental field.

G. Hospital and Nursing Home

All of the above procedures which apply to these providers in addition to special requirements of the investigation.

Exhibit II-6

PURPOSES FOR WHICH "SHOPPING" IS USED
AS AN INVESTIGATION TECHNIQUE

1. PHARMACIES

   A. To verify current "usual and customary" charges to the public.

   B. If complaint generated, to check for "shorting" on the amount of prescriptions dispensed.

   C. If suspected or complaint generated to establish whether or not low-cost generic drugs were dispensed and if trade-name drugs were billed for.

   C. If complaint generated or suspected, to establish if "add-on," nondispensed drugs are added to the Medicaid claim.

2. PRACTITIONERS

   A. Usual and customary.

   B. Establish abuses such as routine screening tests.

   C. Verify if additional charges are made to Medicaid recipients.

   D. Tests ordered by physicians billed to Medicaid but not done.

   E. Comprehensiveness of billed procedures per manual description of specific procedure codes.

   F. If services billed were rendered by an enrolled and licensed practitioner.

3. LABORATORY (through cooperating physician)

   A. Establishing quality of laboratory results.

   B. Improper billing practices.

   C. Usual and customary charges.

4. SPECIAL SERVICES

   A. Optometry

      1. Additional charges to recipient.
      2. Quality and completeness of eye examination.
      3. Usual and customary charge verification.

   B. Dentist

      1. Usual and customary
      2. Billing for services not prior authorized.

Exhibit II-6 (continued)

C. Hearing Aid

1. Usual and customary
2. Type and quality of merchandise dispensed.

orientation to law enforcement investigation techniques and procedures and the Section's philosophical orientation with regard to burden of proof. Medicaid Investigations operates under the philosophy that the burden of proof rests on the challenged provider. If the provider cannot provide proof to support his claims—medical records, for example—the State assumes that the allegation is true, the provider is wrong, and the provider should at least repay funds collected erroneously and possibly suffer other more severe penalties. This placing the burden of proof on the provider—"if he cannot prove it (with documentation), it did not happen"—is a key characteristic contributing to the relative "success" of the Michigan fraud and abuse effort. It is possible, however, only because case law in Michigan supports placing the burden of proof on the provider.

Exhibits II-7 and II-8 present detailed reports of level of effort by type of case for FY73-74 and FY74-75. The figures for FY73-74 are not truly representative since the unit was not fully staffed during the entire period and a great deal of time was consumed in staff training.

The following percentages derived from Exhibit II-8 are of interest since Michigan was the only state able to provide data of this type.

	FY74-75 Hours	% of field investigation time	% of all time
Field Investigation	17,821.5	77	49
Travel Time	2,870.0	12	8
Case Development and Clerical Support	2,495.5	11	7
Subtotal: Time Directly Applied to Cases	23,187.0	100	64
Total Time Applied to Supervision and Non-case Activities	12,784.0	--	36
Total Medicaid Investigations Staff Time	35,971	--	100

Exhibit II-7

LEVEL OF INVESTIGATORY EFFORT, FY1973-74

PS & I SECTION	CASE HOURS: Average hours expended on each	% OF TYPES INVESTIGATED: Cases CLOSED and PENDING agreements — Cases	Providers	%	MAN HOURS EXPENDED BY TYPE: Field Invest	Travel Time	Case Dev & Clerical	TOTAL
PHARMACY	88 cases = 67.3 ea.	59	2,000	2.95	4,019.0	774.25	1,132.0	5,925.25
OSTEPATH	44 " = 40.9	20	1,950	1.03	1,407.5	182.5	210.25	1,800.25
M. D.	68 " = 15.9	26	9,550	.27	829.5	195.5	58.0	1,083.0
LABORATORY	5 " = 2.4	5	107	4.67	6.0	3.0	2.75	11.75
RECIPIENT	154 " = 15.3		(not applicable)		1,509.0	716.0	135.0	2,360.0
AMBULANCE	34 " = 33.4	17	333	5.71	919.0	107.0	109.0	1,135.0
CLINIC	6 " = 47.2		(not applicable)		236.25	43.5	3.25	283.0
NURSING HOME	15 " = 34.5		(not applicable)		422.5	39.5	55.5	517.5
CHIROPRACTOR	3 " = 25.8	1	670	.17	64.25	11.5	1.75	77.5
DENTIST	1 " = .3	1	3,335	.03	--	--	.25	.25
HEARING AID	1 " = 13.0	1	132	.76	9.0	3.0	1.0	13.0
					9,422.0	2,075.75	1,708.75	13,206.5
					Mg'mt. (3-Supv. & 1-Secretary)			6,207.5
					Misc. (In office time)			1,682.0
					Training Time			5,377.25
					TOTAL HOURS			26,473.25

Exhibit II-8

LEVEL OF INVESTIGATORY EFFORT, FY1974-75

MEDICAID INVESTIGATION SECTION	CASE HOURS Average hours expended on each	MAN HOURS EXPENDED BY TYPE				% OF TYPES INVESTIGATED Cases CLOSED		
		Field Invest	Travel Time	Case Dev. & Clerical	TOTAL	Cases	Enrolled Providers	%
PHARMACY	82 cases = 41.7 ea.	2,009.5	359.5	1,050.75	3,419.75	30	1,877	1.6
M. D.	91 cases = 160.7 ea.	5,940.0	623.25	347.0	6,910.25	24	10,550	.23
D. O.	78 cases = 113.3 ea.	7,980.75	1065.0	572.25	9,618.00	33	1,911	1.7
AMBULANCE	34 cases = 23.5 ea.	404.75	115.5	279.5	799.75	17	295	5.8
RECIPIENT	160 cases = 7.1 ea.	772.0	279.5	84.75	1,136.25	--	Not Applicable	--
DENTIST	21 cases = 19.0 ea.	128.0	216.75	54.0	398.75	4	3,194	.13
OPTOMETRIST	10 cases = 41.7 ea.	288.5	66.0	62.25	416.75	3	856	.35
CHIROPRACTOR	3 cases = 69.3 ea.	126.0	66.5	15.25	207.75	--	650	--
LABORATORY	5 cases = 9.8 ea.	35.0	14.0	--	49.0	--	100	--
PODIATRIST	2 cases = 10.3 ea.	10.5	8.0	2.0	20.5	--	285	--
MED. SUPPLIER	1 case = 1.0 ea.	1.0	--	--	1.0	--	350	--
UNLICENSED PROVIDERS	10 cases = 20.9 ea.	125.5	56.0	27.95	209.25	--	Not Applicable	--
		17,821.5	2870.0	2,495.5	22,187.0			
		Mg'mt. (Chief, 4 Supervisors, 1 Secretary)			10,296.00			
		Miscellaneous (In-office Time)			1,027.50			
		Training Time			1,460.25			
		TOTAL HOURS			34,970.75			

From these statistics it is clear the vast majority of direct investigatory time relating to cases is involved in field investigations (89% including travel time) and that a ratio of approximately 1:2 exists for noncase activities including unit management and training to actual case investigations. These statistics are based on the 35,970 hours or 17 person years of effort accounted for by Michigan in FY74-75.

Clearly, Table II-8 demonstrates that the provider case mix will drastically affect the outcome statistics in terms of cases investigated or cases closed. Theoretically by concentrating on the five types of providers that take the least investigation time (dentist, laboratory, podiatrist, medical supplies, unlicensed providers) for an average hours/investigation of 12.2), Michigan could have used its 23,000 hours of investigating time to work on 1900 cases instead of 337. On the other hand, if all investigation time had been spent in the most time consuming area (M.D.—160.7 hours/case), there would only have been a total of 144 cases as compared to 337. It should also be noted, however, that the "M.D. category accounted for the second highest level of dollar recoveries in FY75-76. This exercise is used only to demonstrate the lack of purpose in comparing "numbers of cases" and the difficulty of using a simple calculation to measure the effectiveness of a fraud and abuse control program.

Exhibit II-9 shows the total cases closed and dollars refunded for FY75-76. The total provider cases closed increased from 111 in FY74-75 to 157 in FY75-76. The dollars refunded will be discussed further in the recovery section of this report.

E. Outcomes

The conclusion of each investigation is a Statement of Findings prepared by the investigator. Since the state is recovery oriented, this typically is a calculation of overpayments and the supporting evidence.

Upon completion of the Statement of Findings, the provider is first given an opportunity to respond in writing or to participate in an informal conference with Medicaid Investigations staff. The information given to the provider and subject to discussion concerns those parts of

Exhibit II-9

MEDICAID INVESTIGATION SECTION

Program Integrity Division
Bureau of Medical Assistance
Department of Social Services

12 month report (July 1975 through June 1976

	CASES CLOSED W/O REFUND	CASES CLOSED WITH REFUND	TOTAL CASES CLOSED	DOLLARS REFUNDED
03) Clinic	1	--	1	--
10) M.D.	25	21	46	$340,462.76
11) D.O.	9	12	21	88,581.36
12) Dentist	3	9	12	27,639.39
13) Podiatrist	2	--	2	--
14) Chiropractor	--	2	2	3,564.60
16) Laboratory	7	5	12	698,619.89
18) Ambulance	12	28	40	27,462.68
30) Hospital	1	--	1	--
50) Pharmacy	1	15	16	86,483.20
63) Nursing Home	1	--	1	--
80) Hearing & Speech	1	--	1	--
94) Optometry	1	1	2	2,707.00
Providers	64	93	157	$1,275,520.88
Recipients	176	51	227	66,146.76
	240	144	384	$1,341,667.64
Spl. Projects				28,832.34
			TOTAL RECOVERIES.....	$1,370,499.98

of the findings relating to types of practices in question and the supporting evidence. Specific dollar amounts are not discussed as a matter of departmental policy. This procedure is followed to prevent giving away too much information at initial stages in terms of the depth of the investigation, total dollars involved or the department's potential settlement goal.

The informal discussion process can proceed for as long as the Department thinks it is useful and can include such things as further investigation of points contested by the provider, validation of new evidence presented by the provider, etc.

Exhibit II-10 describes the entire administrative review process available to providers in Michigan.

At any point after the investigation has begun and the provider has been notified, Medicaid Investigations can request claims processing to suspend payments to the provider or withhold a portion of the payments for claims submitted until the issue is resolved. This suspension authority has been upheld by Michigan courts and is used on a discretionary basis depending on the seriousness of the charges, potential amount of money involved, etc. During an investigation the Investigations Unit may also flag a provider so that his claims can be reviewed prior to payment. To some extent suspension of payment depends on the cooperativeness of the provider and at what point Investigations wants to notify him that he is under serious investigation.

If informal procedures fail to produce a satisfactory settlement of the issue, the provider may request a formal hearing under Chapter IV of the Michigan Administrative Procedures Act. These are true adversary proceedings, presided over by an administrative law judge from DSS Bureau of Administrative Hearings. Both sides are represented by Counsel and rules of evidence pertain. The hearings officer has subpoena power and witnesses can be called. Administrative proceedings of this type are used for violations of program regulations; medical issues such as necessity or quality of care issues are usually not involved since these matters are handled by Medicaid Monitoring in the Public Health

Exhibit II-10

MEDICAID PROVIDER ADMINISTRATIVE REVIEW PROCESS

Michigan Department of Social Services
Bureau of Medical Assistance
Program Integrity Division
Medicaid Investigation Section

Providers who have been requested to refund monies to the Medicaid Program have a five (5) step review process at their disposal.

a) In proceeding to each step, the Provider must include the reason(s) in writing, for disagreement and the specific areas still to be discussed and reconsidered. Requests for review on any level shall be made to the Chief, Medicaid Investigation Section.

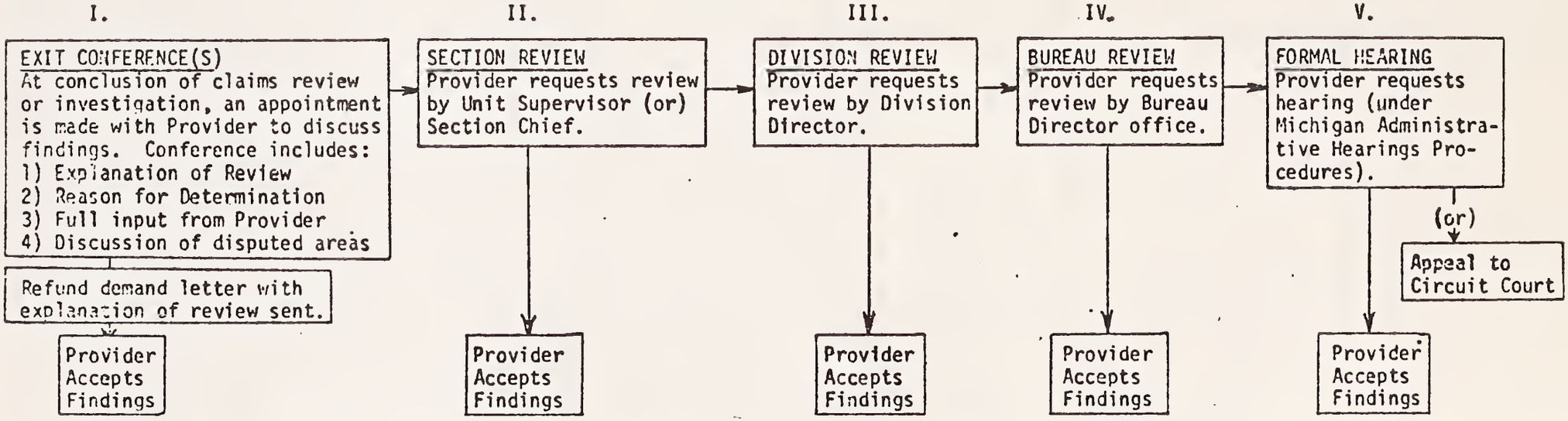
b) The Department shall reply in writing, setting time, date and place of review or hearing.

c) The Provider shall, at all review levels, be able to examine work papers, question Program representatives, present documents or proofs to establish his position, represent himself or have someone speak and/or represent him.

d) The Provider will be given a minimum of 15 days at each level of review.

e) The Provider will be advised in writing of the findings of each review level.

f) Each review level must be used prior to proceeding to the next level.


I.
EXIT CONFERENCE(S)
At conclusion of claims review or investigation, an appointment is made with Provider to discuss findings. Conference includes:
1) Explanation of Review
2) Reason for Determination
3) Full input from Provider
4) Discussion of disputed areas
Refund demand letter with explanation of review sent.
Provider Accepts Findings
II.
SECTION REVIEW
Provider requests review by Unit Supervisor (or) Section Chief.
Provider Accepts Findings
III.
DIVISION REVIEW
Provider requests review by Division Director.
Provider Accepts Findings
IV.
BUREAU REVIEW
Provider requests review by Bureau Director office.
Provider Accepts Findings
V.
FORMAL HEARING
Provider requests hearing (under Michigan Administrative Hearings Procedures).
(or)
Appeal to Circuit Court
Provider Accepts Findings

Department and are not administrative matters. Furthermore, cases for which fraud prosecutions are anticipated are usually presented directly to a prosecutor at the conclusion of the investigation since they involve criminal fraud (although administrative abuses may also exist) and the State would prefer to have the case handled in court rather than in the administrative hearing process.

Although this formal hearing procedure is not used extensively since suspension of payment is a strong incentive for the provider to negotiate a settlement, the existence of the formal hearing mechanism is necessary to guarantee due process to a provider under suspension.

The outcomes of these procedures—informal conferences, formal hearings—are discussed in the following sections.

1. Recovery

This is the most often achieved outcome since the State's prime goal is dollar recoveries. The primary mechanism for recovering funds is deduction from payments for future claims. If the provider has a large Medicaid volume and had been suspended prior to resolution, at the point of resolution the amount unpaid due to the suspension often is similar to the amount of repayment due under the terms of the settlement. If the provider is no longer participating in the program, he is billed directly for the overpayments.

Exhibits II-11 and II-12 show dollar recovery figures for fiscal years 1973-74 and 1974-75. Exhibit II-9 presented these figures for FY1975-76. As can be noted, the actual dollars recovered has increased each year and a majority of cases result in refunds (59% in FY75-76). It is interesting to note that the percentage of cases with refunds and the sources of refund dollars across provider categories changed significantly between FY74-75 and FY75-76. The most significant figures for FY75-76 are in the laboratory area where, although less than half the cases resulted in refunds, the average refund per case closed with refund was $140,000—almost nine times the next highest average of $16,000 per physician or pharmacy case. These "refund dollars" are the amount of the final negotiated settlement and do not necessarily reflect the total amount of

RECOVERIES, FY 1974-75

FISCAL IMPACT -- FY 73-74

CASES CLOSED-FISCAL YEAR 1973-'74

MEDICAID INVESTIGATION SECTION	Agreements Reached				REFUND DOLLARS	PROGRAM SAVINGS (1-YEAR)
	NO REFUND	REFUND	TOTAL	% GENERATING REFUNDS		
PHARMACY	5	43	48	89.58	$ 396,416.24	$ 141,144.05
OSTEOPATH	1	11	12	91.67	237,997.20	199,955.43
M. D.	4	22	26	84.62	169,075.65	109,424.57
LABORATORY	-	5	5	100	50,474.55	59,295.70
RECIPIENT	86	23	109	21.10	32,388.72	69,558.72
AMBULANCE	1	10	11	90.90	8,009.36	2,971.69
CLINIC	3	2	5	40.00	1,643.75	1,956.90
NURSING HOME	-	8	8	100	99,000.00	78,705.88
CHIROPRACTOR	-	1	1	100	70.00	56.00
DENTIST	-	1	1	100	250.00	--
HEARING AID	1	-	1		---	--
	101	126	227		$ 995,370.47	$ 663,068.94

Actual refunds $995,370.47
1 year savings 663,068.94
$1,658,439.41

Divided by Section expenditures 280,000.00 = 5.92 dollars returned for each dollar spent

Exhibit II-12

RECOVERIES, FY 1974-75

MEDICAID INVESTIGATION SECTION	CASES CLOSED - FISCAL YEAR 1974-'75						PLUS
	Agreements Reached						
	NO REFUND	REFUND	TOTAL	PERCENTAGE GENERATING REFUNDS	REFUND DOLLARS	AVERAGE REFUND GENERATED PER CASE	PROGRAM SAVINGS (1-YEAR)
M.D.	11	13	24	54%	$ 69,643.46	$ 5,357.19	$ 31,698.99
Osteopath	4	29	33	88%	665,864.85	22,960.86	304,147.93
Dentist	1	3	4	75%	1,586.00	528.67	7,491.00
Ambulance	1	16	17	94%	32,507.52	2,031.72	14,080.72
Pharmacy	2	28	30	93%	167,156.23	5,969.87	62,085.76
Optometrist	1	2	3	67%	50,150.00	25,075.00	29,146.84
Recipient	77	45	122	37%	105,742.16	2,349.83	112,384.61
Case Subtotals:	97	136	233	58%	$1,092,650.22	$ 8,034.19	$561,035.85
Special Refund Recovery Projects Subtotals	--	138	138	---	$ 107,903.84	$ 781.91	----
TOTALS:	97	274	371		$1,200,554.06	$ 4,381.58	$561,035.85

Actual refunds	$1,200,554.06		
1 year savings	561,035.85		
	$1,761,589.91		
Divided by Section expenditures	380,000.00	=	4.64 dollars returned for each dollar spent

of overpayments or the total amount of identified overpayments. They also do not include any adjustments or denials of claims made by invoice processing unrelated to the specific cases or any retrospective adjustments made to institutional cost bases by CARS. Therefore, they reflect only dollar recoveries for fraud and abuse cases handled by Medicaid Investigations and not the total savings or recoveries experienced by the program.

The "Program Savings" column on the FY73-74 and FY74-75 tables are calculated on the basis of the amount the program would have overpaid if the provider had continued to collect overpayments at the same percentage rate for an additional 12 months.

The total of program savings and dollar recovery has been divided by the cost of operating the Medicaid Investigations Unit in FY73-74 and FY74-75 to calculate a cost benefit ratio (FY73-74—$5.92; FY74-75—$4.64 for each dollar spent). However, the denominator does not include the costs of related and supporting operations such as invoice processing and report generation.

The final point to be made about dollar recovery in Michigan is that suspending payments and debiting providers accounts for amounts owed appears to result in fairly high recovery rates although no statistics are available on the amount of funds owed the State and not collected.

2. Administration Sanctions

The most important administrative sanction available in Michigan is the suspension authority. In FY75, 35 providers were suspended and 8 were terminated from the program. The value of having legal authority to both suspend and terminate cannot be overestimated. One demonstration of this may rest in the fact that these 43 cases represent only 13% of all cases in FY74-75 and the majority of the remaining 294 cases were resolved before suspension with refunds paid to the Department in excess of $1 million. Obviously, there was strong incentive to errant providers to reach settlement and repay funds. [One other factor which should be noted here is that Michigan reimbursement rates are among the highest in the country and, therefore do not provide the negative incentive to drop out of the program that low reimbursement levels in many other states

provide.] Exhibit II-13 presents an example of a letter sent to a provider notifying him of his pending suspension and termination and legal recourse.

3. Prosecutions

Since Michigan is recovery oriented, it has not pursued prosecutions vigorously. Michigan personnel argue that to a large extent the investment in preparing a case for prosecution and getting it litigated is not as valuable as pursuing large dollar recoveries—either in absolute dollars or deterrent value. However, Michigan has prosecuted a few cases and worked with other investigatory agencies to gain prosecution for other offenses. In Michigan criminal prosecutions are handled by local district attorneys with resulting wide variations experienced in the cooperativeness of the attorneys across jurisdictions. This non-prosecution, pro-recovery attitude is probably most clearly demonstrated by the fact that Michigan compiles statistics on dollar recoveries but does not compile statistics on prosecutions.

An example of the philsophy is a very recent laboratory case which the State has not prosecuted, but has recovered $535,000. However, the investigation spread to laboratories in Indiana and Michigan with the potential of extending into other states and Federal investigators are pursuing the case for possible prosecution. In this case Michigan benefits from the recovery and will benefit from any prosecution through the deterrent effect, but the only involvement of Michigan was an investigation.

On occasion charges other than welfare fraud are used effectively. In one case Medicaid Investigations staff while "shopping" were treated by unlicensed personnel. Investigations proceeded to recover payments and terminate the providers; other agency authorities filed charges for practicing without a license.

Exhibit II-13

SAMPLE LETTER—SUSPENSION/TERMINATION

RE: Suspension of Medicaid Payments
Termination of Provider Enrollment

Dear Dr.

Recently Bureau staff conducted an analysis and review of the Medicaid claims and billings submitted by you. These reviews indicate that certain Program abuses and violation of Program rules and regulations exist, such as:

(a) Billing the Program using improper procedure codes; and/or,

(b) Billing the Program for services not rendered; and/or,

(c) Flagrant and persistent overutilization of the medical services with little or no regard for results, the patient's ailments, condition, or medical needs; and/or,

(d) Practicing medicine without a license; and/or,

(e) Submitting fraudulent claims for payment.

Provider participants in the Program are expected to maintain the usual and customary standards set by their profession as well as compliance with rules, regulations, and standards of conditions of participation in the Medicaid Program promulgated by State and/or Federal agencies.

The magnitude of the abuses noted, could result in a loss of Federal monies to the State of Michigan. Therefore, the Department of Social Services, as the SINGLE STATE AGENCY responsible for the fiscal accountability of the Medicaid Program, hereby advises that:

(a) Effective July 17, 1975, all payments have been suspended for claims submitted by you.

(b) Effective September 14, 1975, you will be terminated from participation as a Provider in the Medicaid Program and that no claims for services on or after that date will be further honored by this Program.

Exhibit II-13 (continued)

In the event you wish to appeal your termination from the Medicaid Program, you may request an Administrative Hearing under the provisions of Chapter IV of the Administrative Procedures Act of 1969, as amended. Notice of appeal may be directed to this office or to Mr. Ronald Gruesback, Director, Bureau of Administrative Hearings, Michigan Department of Social Services, P.O. Box 1608, Lansing, Michigan, 48904.

Sincerely,

Bernard Higgins, Acting Director
Bureau of Medical Assistance

MIP:DJM/Jr

III. RECIPIENT FRAUD AND ABUSE CONTROL

Michigan conducts no specific activities with respect to Medicaid recipient fraud and abuse control except to the extent that the Medicaid Investigations Unit coordinates with the Inspector General's Office (AFDC recipient fraud) and attempts to collect recoveries for services paid for on behalf of ineligibles. Therefore, fraud by Medicaid recipients, except those who are AFDC recipients, is not addressed.[1] The complete operation of the MMIS which will provide detailed patient profiles may change this particularly with regard to misutilization. Michigan, however, far in advance of other states recognized the importance and benefit of concentrating its activities on Medicaid provider rather than Medicaid recipient fraud and has consciously shaped its program in the direction of providers.

In Michigan the Welfare Inspector General's Office within the Office of Standards and Investigations is responsible for public assistance recipient fraud. When a recipient who is also a medical recipient is identified as having been ineligible by the Inspector General, the name and period of ineligibility is provided to Medicaid Investigations. Medicaid Investigations reviews the claim's history for the recipient and determines the sum of payments made on that recipient's behalf. This information on medicaid "overpayments" is provided to the Inspector-General and is added to the amount of cash assistance overpayments in the Inspector General's case. The Inspector General seeks restitution or prosecution based on this total amount. (For a detailed discussion of the Inspector General's activities see the GRC report on AFDC fraud and abuse control in Michigan).

The following table presents the data on Medicaid recipient cases previously presented in Tables II-9, II-11, and II-12.

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[1] It should be noted that liberalization in Michigan "medically needy" regulations particularly with respect to transfer of assets have essentially by definition eliminated fraud in this area, which is generally the largest portion of medically needy eligibility related fraud.

	FY 73-74	FY 74-75	FY 75-76
# of cases	109	122	227
# of cases with refund	23	45	51
Refund dollars	$32,389	$105,742	$66,147
Average refund per case with refund	1,408	2,350	1,297

Such cases result in much lower average refunds than provider cases. Furthermore, it is unclear to what extent these refunds are actually collected. On the other hand, the average hours per case (7.1 in FY74-75 and 15.3 in FY73-74) are not significantly lower than some provider categories (laboratory 9.8 hours; podiatrist 10.3 hours in FY74-75).

Michigan also has a very advanced third-party recovery program. Since third party recovery is more directly related to recipients than providers it is discussed in this section of the report. Although the necessity of third-party recovery is required more often because of ignorance concerning the third party, oversight or convenience of billing rather than because of fraud, it is related to fraud and abuse control organizationally in Michigan, financially in that it also recovers significant funds for the Medicaid program and programmatically in that one outcome of the third-party recovery effort can be the detection of both recipient and provider fraud and abuse.

Fraud can occur either in the recipient willfully withholding information as to his/her other source of payment and perhaps receiving direct reimbursement from the non-Medicaid source or the provider willfully double billing both medicaid and the other third party. The review of claims conducted for purposes of detecting third party liability also provides another review with the potential for additional detection of aberrant practices. Therefore, in those states with active third-party recovery efforts, the researchers have gathered data in this area.

In Michigan both the Medicaid Investigations Section and the Third-Party Liability Section are part of the Program Integrity Division. To date the Third-Party Liability Section has shown a cost-benefit ratio similar to Medicaid Investigations (almost $7 recovered for each dollar spent in FY75-76).

A description of the third party liability activities prepared by Michigan and the proposed subsystem they have developed for maximizing recoveries is presented as Appendix II.

IV. AGENCY FRAUD AND ABUSE CONTROL

Agency fraud and abuse control is the responsibility of the Office of Standards and Investigations of the DSS. Within this office, in addition to the Welfare Inspector-General there is an internal audit unit which is responsible for investigating complaints against departmental personnel and continually monitoring procedures and practices to inhibit the possibility of employee fraud and detect aberrant practices. The state had identified no recent cases involving Medicaid personnel. As would be expected, employee fraud is more likely to occur in the income maintenance programs. (See GRC's report of Fraud and Abuse Control in the AFDC program in Michigan). It is state policy that an employee guilty of fraud in either program is to be prosecuted.

V. PROGRAM ASSESSMENT

A. Introduction

Michigan was selected along with other states for inclusion in this study for its potential for having best practices suitable for replication in other jurisdictions. Michigan, in fact, has a reputation as a far advanced state in terms of fraud and abuse control; Michigan staff have testified before congressional committees in this regard. In addition Michigan has hosted many representatives of other states seeking information and assistance.

This study was not designed or intended to be an evaluation of the states which have participated. However, it is of value to present the opinions and comments of state officials with regard to their system and the observations of the analysts involved. This is of particular value with regard to Michigan due to its status in the field and the valuable comments state officials have to make. The following sections present this commentary.

B. Assessment as Reported by State Officials

First, as noted previously Michigan officials recognize that program activities are currently unproductively fragmented between the health department's Medicaid Monitoring Section and Social Services' Medicaid Investigations' Section. By all accounts there is classic discord between "healthniks" and "cops." The problem is exacerbated in its existence by the fact that the two units are located in different departments with their only supervision in common being the Governor. Officials at top levels in both departments are acutely aware of the issue and have been consistently working to improve conditions.

The fragmentation is encouraged by the police-like orientation of the Medicaid Investigations Section. Medicaid officials are acutely aware of the potential dangers of investigative staff performing too much like "cops" and carefully supervise all activities of the Investigations Unit. Strong supervision is considered a necessary trade-off for experienced talented investigators.

Secondly, all state officials are eagerly looking forward to full operation of the S/UR subsystems. They believe the reports generated by the subsystem will have great potential for improving detection and investigation.

Thirdly, Michigan officials point with pride to the leadership orientation of the Department of Social Services. The Department has continually worked to improve the program and provide leadership statewide. Examples of this include discontinuing the contract with the fiscal intermediary and realizing significant advantages as a result; the excellent relationship the Medicaid program has developed with most professional provider groups, and the recent adoption of the uniform practitioner claims form. In this latter case, the state's medicaid claim form, with minor modification has been adopted for the billing of all third parties statewide. As a result providers will not have to deal with a myriad of forms to bill all of the various insurance companies and the state.

It should be noted that to some extent the "success" of Michigan is possibly because state salary levels are relatively high in comparison with most states; therefore, Michigan can both attract and retain excellent staff. This is true of the entire state government, in all departments. It is interesting to note, however, that although the executive departments have worked hard to cultivate understanding and interest on the part of state legislators with respect to Medicaid fraud and abuse control, the state level legislative and budgetary problems of the fraud and abuse control programs are not substantially different than those in other states. Many of the statistics and materials prepared by the fraud and abuse control staff which have given them such renown nationwide were in fact prepared to explain and justify the program to the Michigan legislature. Thus, contrary to popular

myth in many states Michigan is not staffed at significantly higher levels for fraud and abuse control than other states and does not benefit from any particular largess from the legislature. What support there is from the legislature is based on demonstrated competence of program administration and hard work by executive department personnel to explain and "sell" the program to the legislature. The excellent working relationship the executive departments have with professional societies has, of course, facilitated the relationship with the legislature, but these relationships also are built on hard work and demonstrated competence and fairness by state personnel.

Michigan Investigations staff currently have no police powers and are studying the California limited police powers proposal. Although the fraud and abuse efforts function relatively effectively without such police powers, investigative staff feel that subpoena power and better access to the information of other investigatory agencies such as FBI would be of great benefit. The latter issue and "official" status as an investigatory agency appears to become more important as the skills and capabilities of the staff lead them into large and complex cases such as the current laboratory case which involves laboratories in multiple states and a national corporation listed on a major stock exchange. In these cases it is essential that state investigators have the status necessary to work with other agencies such as the FBI, IRS, ICC, SEC, etc. since Federal prosecutions carrying greater penalties than welfare fraud may be easier to prove or may be of greater benefit to the public. However, it is essential that the state and Federal agencies each investigating categorical pieces of a provider's activities be facilitated in sharing information to build a comprehensive case. One idea being considered is to have state investigators deputized as deputy US Marshalls. To summarize, the value and methods of gaining limited police powers for Medicaid Investigations staff are being considered in Michigan although no resolution has been reached.

Staff also commented on the need for better ties between investigations activities and policy setting including the fee schedule determination process. Michigan is not uncommon in this regard. Investigators often feel that as a result of their activities they have the best grasp of where loopholes, negative incentives and other factors detrimental to effective program

functioning exist. However, they have little or no input to the policy-makers who determine the regulations and fee schedules.

C. CONCLUSIONS

Since Michigan is one of the few states with any quantitative data on number of cases by provider type, dollars recovered by case, etc. and the only state surveyed that provided information on the number of investigative hours involved in cases, both in total and by provider type, we have manipulated this data to demonstrate its utility and non-utility. Of particular interest was the question of what quantifiable measures can be used to assess the "success" or even activity level of a fraud and abuse investigations unit. Since it is generally recognized that cases prosecuted are not a reliable statistic because of varying cooperation of actors in the criminal justice system, we have examined such things as total number of cases investigated, dollars recovered, and hours per case. The reader must understand that the ratios involved reflect only the Michigan experience in a given year or two and do not control a wide range of factors which may affect the figures, so that even comparison of Michigan to itself over two years may be unreliable.

Exhibit II-12 (page 32) presented dollar refunds by provider type for FY 74-75 (July 1, 1974 to June 30, 1975). Supporting data on the actual refunds for each of the cases in each provider category was also made available by Michigan. The following discussion analyzes the highest recovery category for the impact of several large cases on the averages presented.

Osteopathic services was the provider category resulting in the highest level of dollar refunds ($665,864) and one of the highest categories in terms of the percentage of cases generating refunds. However, eight cases all involving the same providers in multiple clinic sites resulted in half of this total refund amount ($337,500). For the remaining 21 providers with refunds, the average refund rate per case was only $15,636 with the range of refunds for these 21 providers being $72 to $100,000 as compared to the average refund for all cases of nearly $23,000. By not including this second large refund of $100,000, the average refund per case is $10,874 and the range is $72 to $50,874. Twelve of the 21 cases (excluding the 8 case clinic) resulted in refunds of under $10,000 with five cases yielding less than $500. Exhibit V-1 presents these osteopathic cases stratified by size of refund.

EXHIBIT V-1

STRATIFICATION OF OSTEOPATHIC CASES FY74-75
BY SIZE OF REFUND

	# of cases	% of total			
$ 1-500	5	15	33		
500-5,000	6	18		45	
5,000-25,000	4	12			57
25,000-50,000	4	12			
50,000-100,000	2	6			62
337-500	8 (1 clinic)	24			
Cases with no refund	4	12			
	33	99			

If the one clinic case is counted as 1 case instead of 8, the 3 cases in the $50,000+ categories were only 12% of the cases investigated, but accounted for 73% of the refunds.

When viewed from the perspective of this analysis osteopathic cases are not necessarily as profitable as could initially be assumed since several large cases have effectively skewed the data. Notably in the following year the average refund per case with refund for osteopathic services was $7400.

A second analysis arranges this data to show the recovery levels by provider type and to attempt to identify the provider types with the highest recovery potentials. Ranges of refund size are presented below for the FY 74-75 cases.

Provider type	Range	Mean refund per case with refund
M.D.	$ 35- 25,000	$ 5,357
Osteopath	72-337,500	22,960
D.D.S.	30- 1,091	528
Ambulance	34- 11,782	2,031
Pharmacy	186- 45,569	5,969

Exhibit V-2 illustrates the distribution of recovery cases by amount recovered. Most cases fall at the low range of dollar recoveries.

In all categories except dental which is not illustrated as there are not enough cases to be truly representative, more than half the cases with dollar recoveries fall below the median dollar level and on the average 68 percent of the cases return refunds at the median level or below.

The figures below present average refund per case for FY 75-76 compared with FY 74-75 by the four provider categories.

Provider type	All cases		Cases with refunds	
	FY75-76	FY74-75	FY75-76	FY74-75
M.D.	$7,401	$ 2,902	$16,212	$ 5,357
D.O.	4,218	20,178	7,382	22,960
Ambulance	6,866	1,912	7,938	2,012
Pharmacy	5,408	5,572	5,766	5,970

Exhibit V-2

AMBULANCES (16 cases) (in $1000)

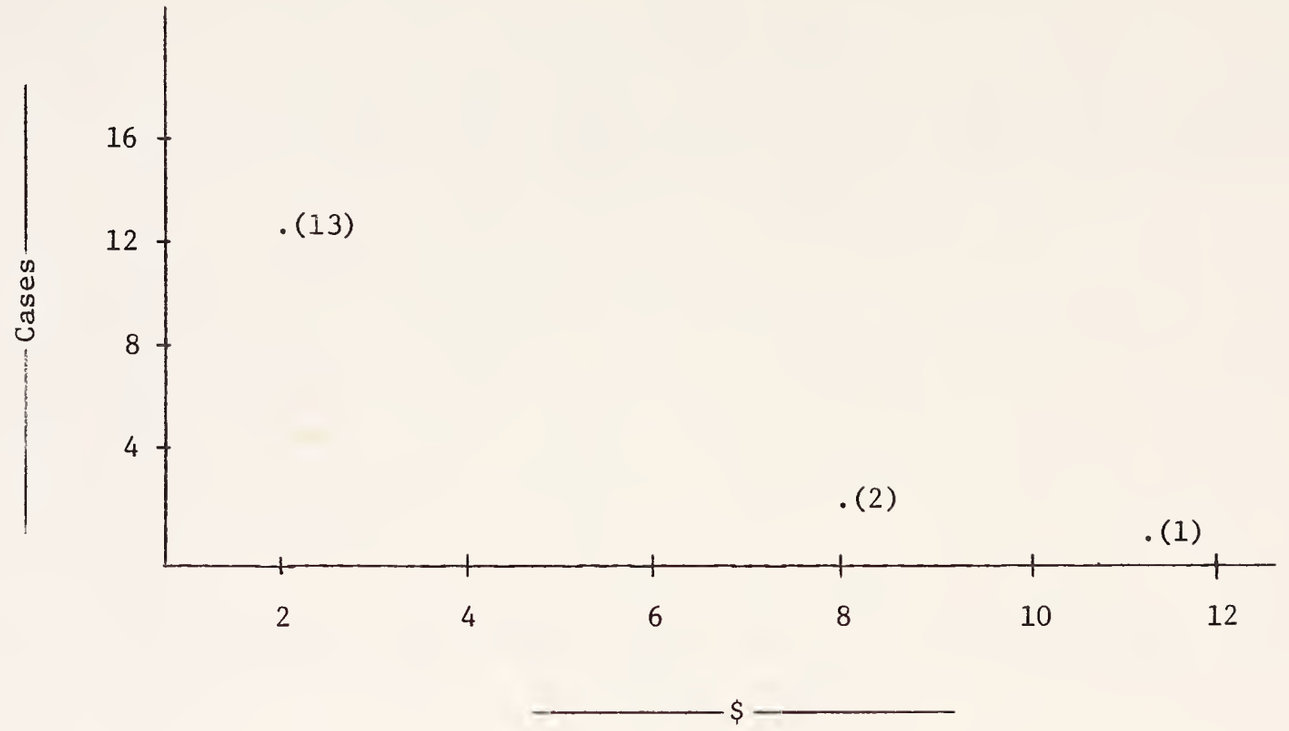


Exhibit V-2 (continued)

D.O.s (22 cases)

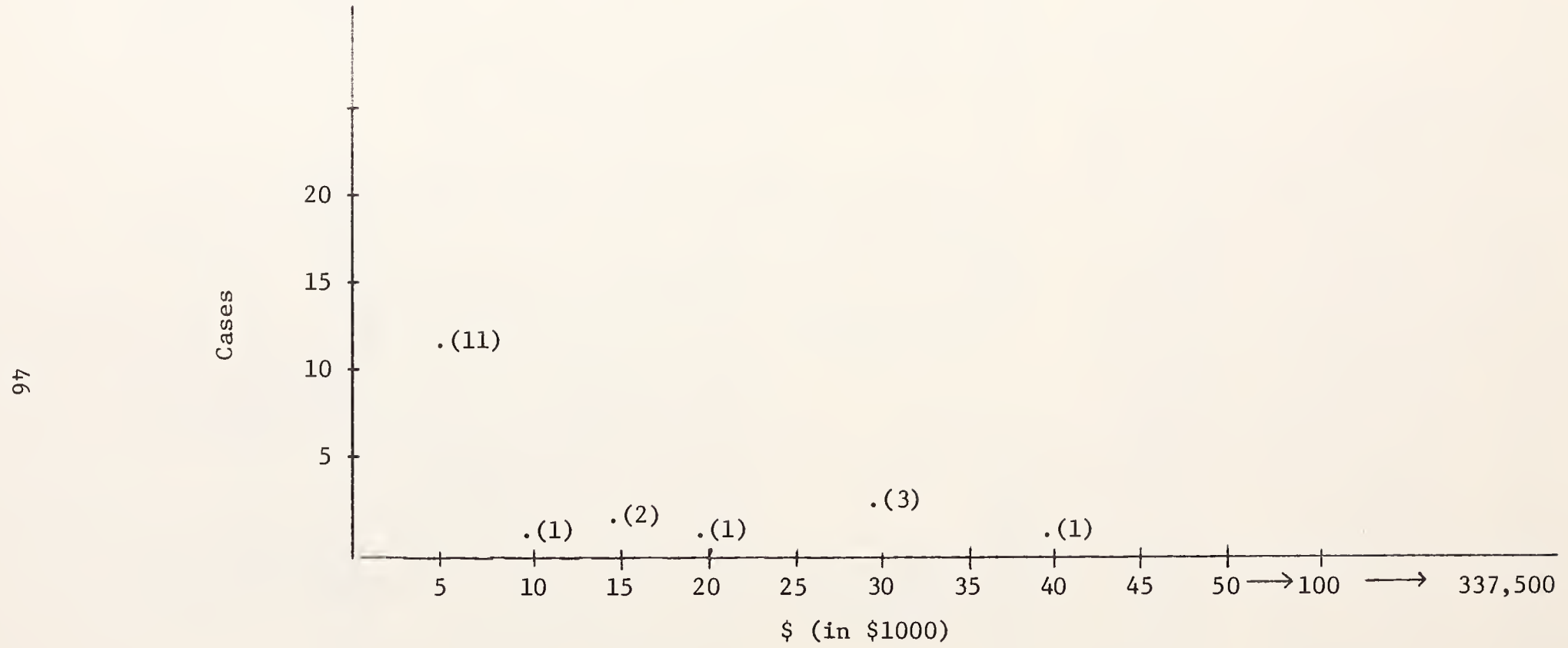
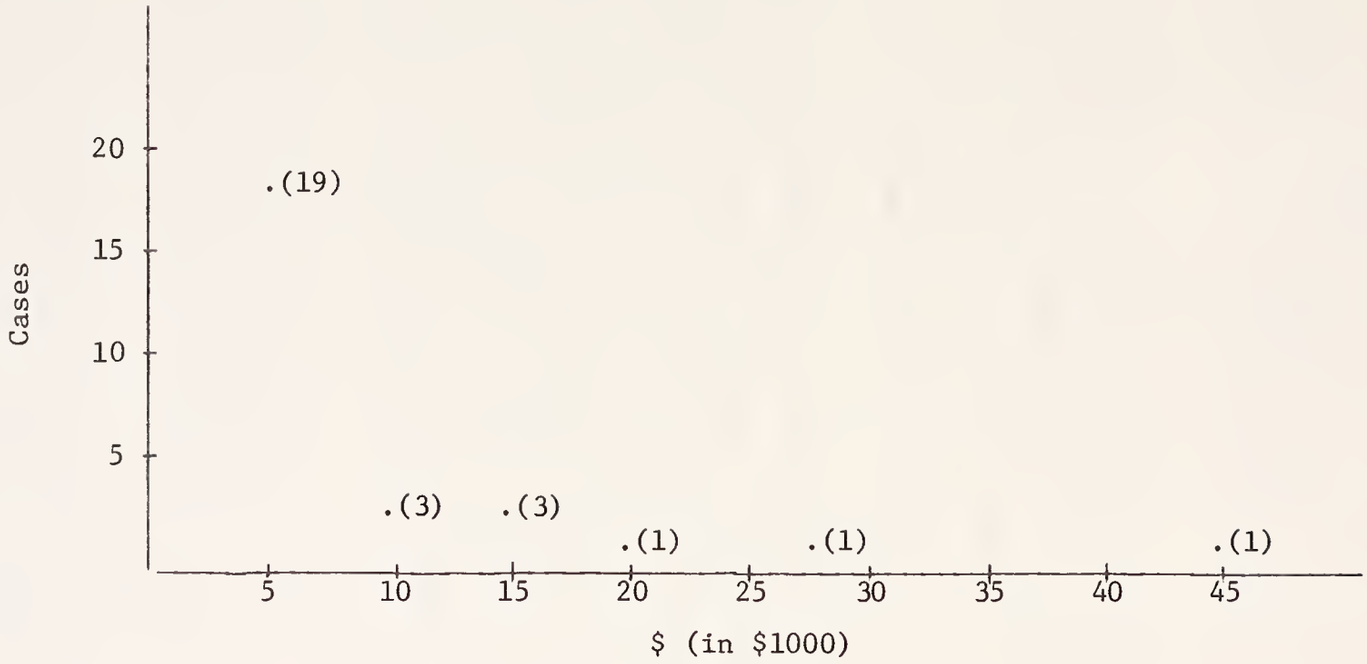


Exhibit V-2 (continued)

Pharmacies (28 cases)



Looking at all cases, physicians and ambulances accounted for the highest average refunds in 75-76; these same two categories represented the lowest recoveries the previous year. This holds true, but to a less dramatic degree on the basis of cases closed with refunds. This suggests that a variables other than provider type are more significant in determining the average refund per case. States should be cautious in basing a given year's activities on the experience of a previous year or the experience of other states.

Another point should be noted. In both years the average refund per physician case shows a significant difference when the denominator is changed from all cases to cases with refunds while other categories remain relatively constant. This is of course reflective of the fact in FY 75-76 less than half the M.D. cases were closed with refund and in FY 74-75 only 54% were, whereas in the other categories many more than half the cases were closed with refunds in both years.

Perhaps the most interesting thing shown by this table is the relative consistency of the pharmacy category—a narrow variance in average refund amounts and a high percentage of cases closed with refunds in both years.

By using the 1974-75 data on total hours of investigative time in each provider category previously presented, and the total refund by provider category, numbers on dollar refund per hour of time can be generated. This data is presented in Exhibit V-3. From this table it can be noted that investigations of physicians provide a significantly lower return rate per hour of investigative time than the other provider categories, at least during FY74-75.

In conclusion there are several statistical measures which have bee generated which could be argued to demonstrate the productivity of investigating various provider categories if recovery is the program goal. These are summarized in Exhibit V-3.

As can be seen from this exhibit, except for the consistent ranking of the pharmacy category as number 2, there is not a great deal of consistency across any of the statistics. Physicians rank 3 or 4 across all categories, but in the case where it ranks 3, there is a significant difference between 3 and 4.

EXHIBIT V-3

REFUNDS BY HOURS OF INVESTIGATIVE EFFORT
BY PROVIDER CATEGORY, FY 1974-75

Ambulance	Total hrs/ all cases	Total refunds	Refund $/hr of investigative time	(Rank)	Av. refund per case	(Rank)	% of cases generating refunds	(Rank)
M.D.	6,910	69,643	$10.08	(4)	5,357	(3)	54	(4)
D.O.	9,618	665,865	69.23	(1)	22,960	(1)	88	(3)
Ambulance	800	32,508	40.64	(3)	2,031	(4)	94	(1)
Pharmacy	3,420	167,156	48.88	(2)	5,969	(2)	93	(2)

In summary, Michigan presents various statistics which on face value suggest a successful program. Lacking data from other states with which to compare, we have compared Michigan to itself on various criteria in an attempt to demonstrate the utility and variability of such measures.

VI. BEST PRACTICES

A. Introduction

The purpose of visiting states in this study was to determine exemplary practices which would enhance other states' fraud and abuse control programs if replicated. Since no state was expected to have an entirely model program, a mix of states with differing strengths and weaknesses was selected. In order to evaluate the extent to which the environment allows the "best practice" to exist or succeed and, therefore, to be able to assess the replicability of the practice to other environments, it was necessary to review the functioning of the entire Medicaid program in each state. Indeed, the process of fraud and abuse control as defined through this study from prevention through administrative or criminal outcomes involves almost every aspect of how the program is administered in each state. Necessarily, the assessment of "best" is based in large part on each state's assessment of its program and the analyst's knowledge of the uniqueness of the practice and value to other states. Since the Michigan situation contributes many ideas in the areas of Federal options and best practices, we have attempted to group them in general conceptual areas in the following sections of this report.

B. Staff Selection and Characteristics

Michigan exemplifies staff of excellent qualifications and a high degree of commitment. There appear to be two keys to attaining such staff excellence and enthusiasm. The first is carefully analyzing the tasks to be accomplished and the skills required and hiring staff suitable for the resulting positions. In Michigan this has occurred; Medicaid Monitoring staff in the health department are health analysts and statisticians; Medicaid Investigations staff are investigators with law enforcement backgrounds or individuals with health backgrounds and a strong interest in and capacity for investigations; and top administrators have strong management backgrounds -- some from the insurance industry. Each unit appears to be staffed with individuals with backgrounds and interests suitable for their jobs. The least successful fraud and abuse control programs we have seen tend to be staffed with individuals with backgrounds not related to their fraud and abuse control functions who flounder in both health

terminology and investigative procedures. In addition, individuals with appropriate backgrounds appear to understand the issues and the standards, to not be intimidated by "professionals," i.e., providers, and to understand the necessity for confronting and penalizing providers who are out of line with normal standards of practice and program regulations.

The second major factor in the success of the "people" in the Michigan program is the quality of top management. Top managers also appear to have appropriate "content" backgrounds and to have previously held management positions. The result is that they not only can budget, supervise and conduct the other tasks necessary to operate a division or unit, but also understand the larger situation. For example, Michigan management has focused not only on internal procedures, but also external support. The support of most of the professional societies in Michigan for the fraud and abuse control efforts is the result of top management recognizing the need for such support and actively working to achieve it. Michigan management has also recognized the value of data in selling and justifying the fraud and abuse control effort. The data are not only used to manage staff and provide positive feedback as to results ("we recovered a million dollars this year"), but it is also used to convince top officials in the department and in the legislature and the public of the value of the program and its integrity.

Clearly, any fraud and abuse control effort is largely dependent on the goals set by the governor or the department head. If these leaders are more interested in not upsetting providers than in protecting the Medicaid program's integrity (and the taxpayer's dollar), no amount of talented, dedicated staff will be able to achieve results. However, if the single state agency is committed to program integrity, staffing, in terms of specifying job requirements and tasks and matching individuals to them, is a key criterion for success.

There are a few additional comments to be made on this subject:

1. Observations suggest that hiring appropriate staff in the first place is far superior to providing training for less appropriate staff. Particularly in the area of investigations, someone who has chosen a career of investigation appears to have a personality characteristic in addition to skills which make him/her a better investigator in the long

term. There are, of course, exceptions to this in all states, but in general the rule seems to hold. The most notable exception seems to be pharmacists. Not only Michigan, but also other states have pharmacists who are superb investigators.

2. Even though Michigan appears to be well staffed, when asked what thing would most improve the Michigan fraud and abuse control program, the Director of the Program Integrity Unit said training. He cited in particular information on successful prosecutions.

3. There are various philosophies of fraud and abuse control and each state should consider its philosophy and goals prior to specifying jobs. The health analyst function seems to remain constant for surveillance and utilization review. Some states, however, are very recovery oriented and others are prosecution oriented. Appearance would suggest that Michigan is prosecution oriented due to the number of ex-police on its staff. In fact, it is recovery oriented, but seems to have selected investigators comfortable with this approach.

4. Overzealousness or "police brutality" is a concern of every police department. It must also be a concern of other investigation agencies. Staff recruiting, interviewing, selection and supervision procedures must take this problem into account and mitigate against it if ex-law enforcement officials are sought as staff.

To summarize, Michigan's "success" in large part is based on its staff and evidence from other states suggests that Michigan is not a unique group of personalities, but rather that careful staff selection has created this circumstance.

Key factors are:

- Identifying program goals and objectives, specifying job descriptions and requirements in terms of tasks to meet the objective, and hiring staff with the requisite qualifications.

- Hiring managers with positive management experience as well as investigative knowledge who know the relationship of the units in question to the larger universe and who have a willingness and ability to stand up to political/legal pressures if necessary.

An anecdotal comment on the quality of Michigan's staff is that several other states said that they could do a better job of fraud and abuse control if they had as many staff as Michigan, when in fact Michigan has about an average level application of staff resources to fraud and abuse control. Other states tend to perceive the "success" of the Mighican effort as the result of high numbers of staff, when, in fact, in our judgment there are not substantially more staff and the "results" can be attributed to other factors.

C. Organizational Structures

Michigan is an example of another state where the spearation of the largely medical abuse related functions (surveillance and utilization review) and the "investigations" functions appears to be effective. This may appear to be a spurious assumption since all parties agree that "separation" in Michigan is really fragmentation. However, each unit appears to have a clear understanding of its objectives and functions and to operate effectively and efficiently, although the synergistic effects of the two units are not fully realized.

Based on the states visited, it seems clear that investigators per se are necessary, but that their style and techniques are not compatible with the equally necessary personnel with program or health backgrounds. Furthermore, as long as coordination occurs at upper echelons, there appears to be no necessity for there to be one single agency. In fact, when combined into one agency the goals and functions appear to become confused and no one operates effectively. In separate agencies each has clear missions against which performance can be measured.

This is not a recommendation that S/UR functions be located in the Health Department in all states or that investigations necessarily be located in the Medicaid agency. However, the separation of the two shops appears to be advantageous.

An additional, and uniquely bureaucratic, advantage of separate units relates to job classifications. Within the same units we have found that job titles tend to be from the same series for all employees. If the investigations and S/UR functions are combined into one unit, what tends to happen is that civil service classifies all jobs as either "investigator"

or "health analyst" and the benefits of the two types of skills are often lost to the unit. This is in addition to the normal attrition which might occur among individuals who are not comfortable in the combined unit. The end result of both civil service processes and normal attrition would probably be one unit with only one set of skills to conduct both functions.

D. Information Processing

1. Output Reports

Although not fully operational in terms of output reports,[1] the MMIS is clearly a key contributor to the effectiveness of the Michigan fraud and abuse control effort. As seen in other states, the output reports are the single most effective detection mechanism available to the state. The Michigan MMIS S/UR subsystem is interesting for two reasons.

- As noted in other states the standard output reports contained in the HEW design specifications are not necessarily the most valuable reports for today's problems. Michigan has recognized this and is modifying the system. States with MMIS experience should be sharing that experience with other states that are designing and implementing the system since some standard programs such as treatment analysis do not appear to be useful and programs to deal with new problems such as prescription splitting are being developed and run in some states.

- Michigan is modifying the system concurrently with implementation. Although profiles are not yet being generated for all categories of service, Michigan has already begun experimenting with the most useful exception criteria for the provider categories that are available. This is another example of the good management in the Michigan program which is always seeking program improvement. Michigan is testing both standard deviations from provider group averages and absolute values to assess which criteria at what values provide the most useful exceptions. This experience and expertise with exception criteria should also be shared among all states.

If the MMIS is to achieve its greatest potential and maximize the value of machine processing, the states with implemented MMIS must share that experience with developing states and the certified states must continue to refine and develop the system to improve upon the basic design specifications.

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[1] MMIS was certified June 1976 by DHEW.

2. Relationship of Computer Operations to Program Management

A corollary to the prior point is the accountability of the computer staff to the program staff in Michigan. As noted previously, the Division of Management Information and Payment Systems is part of the Bureau of Medical Affairs. Thus, the Division Director for Computer Operations is an equal to the Division Director for Program Integrity and both are responsible to the Bureau Chief and operational head of the Medicaid program.[1] This organization exists throughout the Department of Social Services where each program director has his own computer staff who are responsible for representing that program in interfaces with the department (health and social services) data center which actually operates and maintains the machines. Thus, each program head has authority over and control of his computer staff and the degree to which the computer staff meets his program's needs. Furthermore, when issues of availability of machine time and priorities between programs need to be decided, bureau chiefs all have inputs to the director of the department on their program's needs, priorities, and time constraints.

This organizational structure appears to not only ensure the computer staff provide needed information and services on time, but also that their allegiance is to the program. This integration makes computer support truly supportive, integrates the systems budget into the overall program budget, and facilitates computer staff working with other program personnel to design new systems and subsystems, etc. to improve program performance.

This is truly impressive in Michigan because there are tangible results in systems' modifications, fraud and abuse control staff access to data, etc., apparently without introducing major systems inefficiencies. We have seen other states where computer operations are centralized in the unit equal to the program units organizationally and program staff complain that they wait three to six months for routine reports and can not get new computer programs implemented which would greatly facilitate their work. The complexity and volume of both the Medicaid and AFDC programs are such that computers are essential and that in many ways whoever

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[1] S/UR subsystem is being implemented by Medical Monitoring/Department of Health.

controls the computer runs the program. Once all computer operations and programming are outside the control of the program director, the director of computer operations has his own "turf" to protect and does not necessarily have the same objectives as the program chief. Since the computer unit is usually evaluated on the efficiency of claims payment, and not on fraud and aubse control criteria, for example, the computer unit head may cut corners that keep his claims turnaround time down even if it means some incorrect or duplicate claims are paid. Each new S/UR report means time and money out of "his" budget with no direct value to the computer shop.

In summary, the organizational model in Michigan appears to assure that the essential support function of computer operations is integrated with other program functions to achieve the overall goals and objectives of the Medicaid program.

3. "Front-End Claims Management"

Perhaps because the output report activities are not totally operational, the front-end edit and claims processing capabilities of the Michigan system are more visible. Occasionally sophisticated output reports obscure these more routine functions. There is no data to describe the extent to which good claims processing prevents fraud from being attempted or prevents invalid claims from being paid since all data bases are made up of paid claims. However, everyone agrees to the importance of "front-end" systems. A few examples of their value include:

- Providers are understandably less likely to submit incorrect or invalid claims if the system negates the billing time by automatically rejecting the claim. The truly fraudulent provider will attempt a more sophisticated scheme, but the vast majority will not be tempted to simply "overkill."

- Effective claims editing will thwart some common types of fraud and abuse through rejection of claims -- even if there is willful intent by the provider to defraud the program. In effect, in some categories such as duplicate billing, the provider can not defraud the program even if he wants to. Thus whole categories of problems are eliminated and the succeeding parts of the system and their costs -- detection, investigation,

prosecution -- need never be concerned with these types of fraud and abuse. They simply can not occur.

• A claims processing system with a rapid turnaround time has positive impacts on the entire program. For example, providers are more likely to participate if they know their bills will be paid in a reasonable period of time and that by taking Medicaid patients they are not going to jeopardize their cash flow. By providing a reasonable turnaround time and, therefore, cash flow to providers, these businessmen (and providers are businessmen) do not have the incentive to defraud the program to recover the costs of paper work and the costs of funding a cash flow problem which they incur due to slow payments. Finally, reasonable turnaround (Michigan pays 97 percent of all valid claims within 30 days) means that Mighican has no problems with factoring firms. There is little incentive to the provider to factor his claims if he is getting paid within 30 days. Although factoring itself may not be fraud, it demonstrably encourages fraud and abuse as providers overbill to recoup the dollars lost through factoring. Factoring firms have also conspired with state employees to get their claims paid faster than others. Effective claims processing in all states, with its many other benefits would effectively eliminate the problem of factoring. In effect, states induce their problems with factoring through slow claims processing.

• Rapid claims processing also eliminates the opportunity or possibility for certain types of abuses or frauds which providers may commit unwittingly while just attempting to get paid. In one state duplicate claims is a major problem, not because providers are trying to defraud the system, but because when they have not been paid after several months they assume the claim was lost and submit a second. This creates a great deal of extra paper work both for the provider and for the program.

• Front-end editing means that many types of fraud and abuse never occur so that staff reviewing output reports can invest their time on the truly fraudulent providers and elaborate schemes. Staff do not have to spend time checking on the provider who submitted duplicate claims or billed for a non-existent recipient because a billing clerk miscopied the recipient identification number. These claims are never paid and therefore

never show up on exception reports. This not only saves staff time from being used on petty matters, but gives the provider rapid feedback on incorrect bills so they can be resubmitted and paid if appropriate and spares the innocent provider unnecessary letters and meetings with fraud personnel and any suggestion of any adversary relationship with the program.

E. Coordination of Benefits and Recoveries

A best practice observed in Michigan which relates directly to fraud and abuse control is coordination between AFDC fraud investigators and Medicaid investigators in the area of recipient fraud. It is a comment on the fragmentation of public assistance programs that this simple mechanistic activity qualifies as a best practice. In Michigan AFDC investigators routinely provide the identification of ineligibles to Medicaid investigators who search the claims histories and provide information to the AFDC investigators on the total of Medicaid claims paid during the period of ineligibility. Action taken against the recipient then encompasses both AFDC and Medicaid overpayments made by the state to or on behalf of an ineligible. Dollar refunds of this type to the Medicaid program in the three fiscal years reported averaged $80,000 a year. We do not suggest that there is a major fraud problem among Medicaid recipients or that substantial efforts by the states should be made in this area, but the lack of routine coordination and information exchange between medical assistance and assistance payments which occurs in many states should be intolerable. Of course some AFDC ineligibles would be eligible for medical assistance through spend-down provisions, but since the AFDC file includes income data and the medical claims data is easily available, calculating spend-downs is a simple mathematical calculation in the AFDC investigation process.

Michigan is also a leader in a related area, the area of third party recoveries which will soon be addressed by another study and has not been discussed in detail here. By the estimate of Michigan and several other states, third party recoveries offer a much greater potential for large monetary recoveries by Medicaid programs than does the fraud and abuse area. It must be remembered, of course, that program savings is only one of the reasons for having a fraud and abuse control program. Program integrity and public confidence in the government's ability to fairly and

correctly administer a public assistance program that services the intended beneficiaries -- the needy recipients -- is also a key issue.

F. Administrative Sanctions

Michigan has the administrative tools of suspension, termination and automatic recoupment of funds through debiting a provider's claims account available ot it. In the areas of investigation and outcomes, the availability of these recourses appears to be the single most significant characteristic of effective fraud and abuse control efforts. Any state which does not have these tools might well focus only on the few actionable fraud cases leading to prosecutions. Without these "teeth," warning letters, informal conferences, and any other activities except pure fraud investigations may be of limited benefit since there is no incentive for the provider to cooperate, negotiate or refund unless it is in lieu of criminal prosecution.[1] Such prosecutions require a great deal of investigatory effort, take a long time in the courts, require willingness and expertise on the part of prosecutors and courts, and in even a large state like Michigan would probably only involve a very small percentage of providers each year -- without touching the abusive providers who do not actually commit criminal fraud. Clearly "effectiveness" encompasses both the deterrent effect of a few successful prosecutions, and administrative action against a much greater number of providers who are abusing the program. An effective program must be able to deal with a large number of providers each year whose abuses of the program range from small infractions to large fraudulent schemes. (If only 1 percent of Michigan providers were abusing the program each year the result would be 230 cases. Furthermore, some abuses do not legally constitute fraud, but can result in very large overpayments.

In lieu of supporting Federal regulations, states have taken various approaches to gaining the use of administrative sanctions. A characteristic

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[1]The only exception is the use of civil recovery suits to collect "overpayments." However, we have yet to see a state which has effectively used civil suits to recover funds as a tool of fraud and abuse control.

which to some extent seems to describe a state's commitment to fraud and abuse control is the willingness of the state to incur a court case over its actions. Some states seem to hide behind their lack of legal authority while taking no action whether through legislation, regulation or litigation to improve their legal status. In Michigan the state has been taken to court, but its action in suspending payments and debiting accounts has been upheld, thus establishing the principle in Michigan case law. Once the "teeth" exist states can adopt various modus operandi in their investigating style and relationships with suspect providers.

G. Attitude/Operating Procedures and Policies

A distinguishing characteristic of effective programs seems to be attitudes which have allowed selection of really workable and effective programs and procedures. This in part stems from the quality of staff as discussed in Section B above, but is discussed separately here due to the value of the Michigan attitude. Michigan's attitude in relation to provider fraud is completely the reverse of traditional jurisprudence where the burden of proof is on the accuser. Some jurisdictions have accepted this traditional approach and invest endless hours of investigation only to be able to "prove" nothing. Michigan takes the position that the provider submitted a claim for a particular service, and that therefore there must be documentation or evidence to support the claim. This is not unlike a company requiring receipts to support expense vouchers, an auditor requiring invoices to support allowable costs, and peer review groups requiring test results and medical records to support diagnoses and procedures. If the provider can not produce the supporting evidence then he did not provide the service in Michigan's view, and appropriate action is taken. By shifting the burden of proof, Michigan has saved untold hours of investigations and greatly increased the efficiency of the fraud and abuse control process. Only in the few cases which actually go to prosecution does the burden of proof have to rest with the state. An example of a case where this attitude is useful is billing for services not provided, for example extremely high volume or gang visits to nursing homes. If the claims records show that a provider is billing for 150 to 200 Medicaid visits a day, instead of investigators sending letters or interviewing hundreds of recipients to see if

the services billed for were actually received, the investigator merely asks the provider for the medical records for selected recipients (usually through a visit to the provider's office without specifying the names of recipients in advance to avoid alterations in the records). If the records do not show a visit for the day in question, or the results of the laboratory tests billed for, or documentation of whatever other service is in question, Michigan takes action to gain recoveries for these overpayments. Thus one visit rather than many interviews is involved in terms of investigative time. If the records exist, but investigators are still suspicious, they can go on to the steps of interviewing recipients, etc.

It should be noted that one of the most time consuming parts of an investigation is reviewing claims and comparing them to provider records to determine the amount of overpayments. There is a distinction between an investigator being able to determine to his satisfaction and that of his supervisor that a claim is incorrect or spurious and "proving" that the claim represents an overpayment. Using the reversal of burden of proof, investigators make the first level determination and it is up to the provider on a claim-by-claim basis to prove the claim is valid and does not constitute an overpayment.

To summarize, an "effective" fraud and abuse control program must be prepared to develop and pursue cases both through criminal fraud prosecutions and through administrative sanctions channels. Administrative tools such as suspension, termination and enforceable recoupment must be available to fraud and abuse staff. Having these administrative tools, fraud and abuse control staff should operate under policies which use their time at maximum efficiency. The Michigan approach of shifting the burden of proof to the provider is one effective approach to saving staff time and gaining results.

H. Relationships with the Provider Community.

An active fraud and abuse control program has to have suitable relationships with the provider community if it is to survive and not do great damage to the legitimate goals of the Medicaid program. Michigan, by adroitly pursuing provider cooperation from the start, has freed itself from the fear of large scale provider dropout, so often given by some

states as a reason for not pursuing fraud or abuse control. Letters and public pronouncements from organized medicine in Michigan attest to the fact that physicians, at least, recognize that program integrity works in their best interests. There was no magic involved in achieving this result; it simply required recognition of the necessity for mutual understanding and support by the state, persistence and political activity in presenting the program integrity issue to provider groups, and a straightforward, honest attitude on the part of the state.

Other jurisdictions such as New York City and Massachusetts have also realized the benefits of establishing dialogues and working relationships with provider groups. Most importantly providers must be assisted in understanding that the fraud and abuse control activities are not anti-provider interests but rather directed at the few providers who give the entire industry a bad name; that fraud and abuse drive up program costs and result in fewer dollars to pay reasonable fees to legitimate providers; and that Medicaid program personnel are reasonable people willing to work with providers to resolve program problems. The benefits to the program of such a relationship are a decreased potential for provider dropout and law suits filed on behalf of entire provider groups, peer pressure and support of the legitimate providers for the program's efforts against abusive providers, and decreased opposition or increased support for the program by provider groups with respect to the legislature and the public.

Appendix

MICHIGAN THIRD PARTY LIABILITY

MICHIGAN THIRD PARTY LIABILITY

The Medical Assistance Program (Medicaid) was initiated in Michigan on October 1, 1966. The Federal Law (Title XIX) requires the State Agent administering the Program to exhaust all known resources prior to utilization of Medicaid funds.

It prohibits the State from withholding payment when: the third party resource is not immediately identified; the liability is not currently established; or the amount is not currently available.

It requires the State to identify the resource, ascertain the legal liability, and seek reimbursement from the third party.

During the early years of the Medicaid Program, after the Third party provisions took effect on March 31, 1968, there was an absence of significant activity in the area of identifying and exhausting third party resources.

However, in early 1972, when the Bureau of Medical Assistance began to phase in, as the new fiscal agent responsible for administering the Program, it formed the Third Party Liability Section.

In the absence of specific federal guidelines regarding procedures and methods, this section was responsible for developing, implementing, and operating a program which would identify and seek reimbursement from third party resources.

Vague laws, conflicting laws and opposition from lower management personnel in many segments of the insurance industry contributed to adverse conditions notwithstanding, our Third Party Liability Section has operated from inception at a successful cost-benefit ratio:

FY	COST	RECOVERY	BENEFIT/COST RATIO
73/74	$285,000	$1.2 million	$4.21/1
74/75	$345,816	$1.8 million	$5.20/1
*75/76	$313,040	$2.1 million	$6.84/1

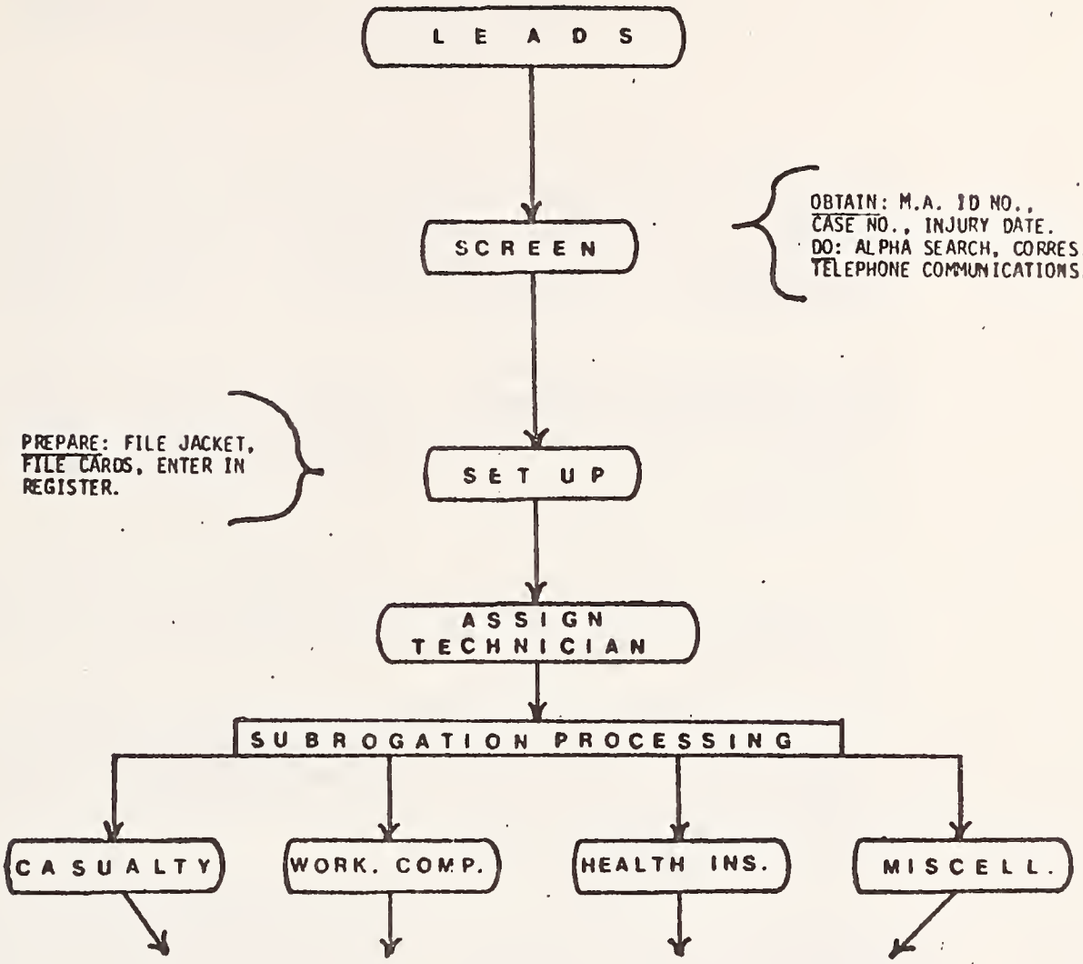
(* figures to date of 2/29/76)

Moreover, the recovery program operates without causing delay, interruption, or deprivation of medical services to persons who are eligible for the benefits of Medical Assistance.

The experience and findings of this section during the past three years reveal that our recovery program has just completed its embryonic stage. The passage of recommended amendatory legislation, coupled with an all-out information-gathering effort in the eligibility determination process, will enable the Department, through automated data processing techniques, to achieve maximum results at an even more lucrative cost-benefit ratio.

MICHIGAN
THIRD PARTY LIABILITY OVERVIEW

MANUAL SYSTEM



MAINTAIN FILE DOCUMENTATION

IDENTIFY AVAILABLE INSURANCE

ASCERTAIN INJURY DATE

ORDER MEDICAL EXPENDITURE HISTORY PRINT-OUTS

DETERMINE EXPENDITURES FOR SPECIFIC INJURY

DETERMINE EXPENDITURES COVERED BY SPECIFIC HEALTH INS. POLICY

COMMUNICATE WITH ATTORNEYS, RECIPIENTS, INS. CO., ETC.

ANALYZE LIABILITY

EVALUATE SUBROGATION POTENTIAL

NEGOTIATE RECOVERIES

PREPARE CLOSING REPORT

THIRD PARTY RESOURCE SUB-SYSTEMS

The objective of the following proposed "Third Party Resource Sub-Systems Data Bank" is to incorporate into, or supplement the Client Information System with sub-systems that will exhaust all possible resources by the ultimate generation of a certified Post-Payment Billing Form to an insurance carrier, or other third party resource.

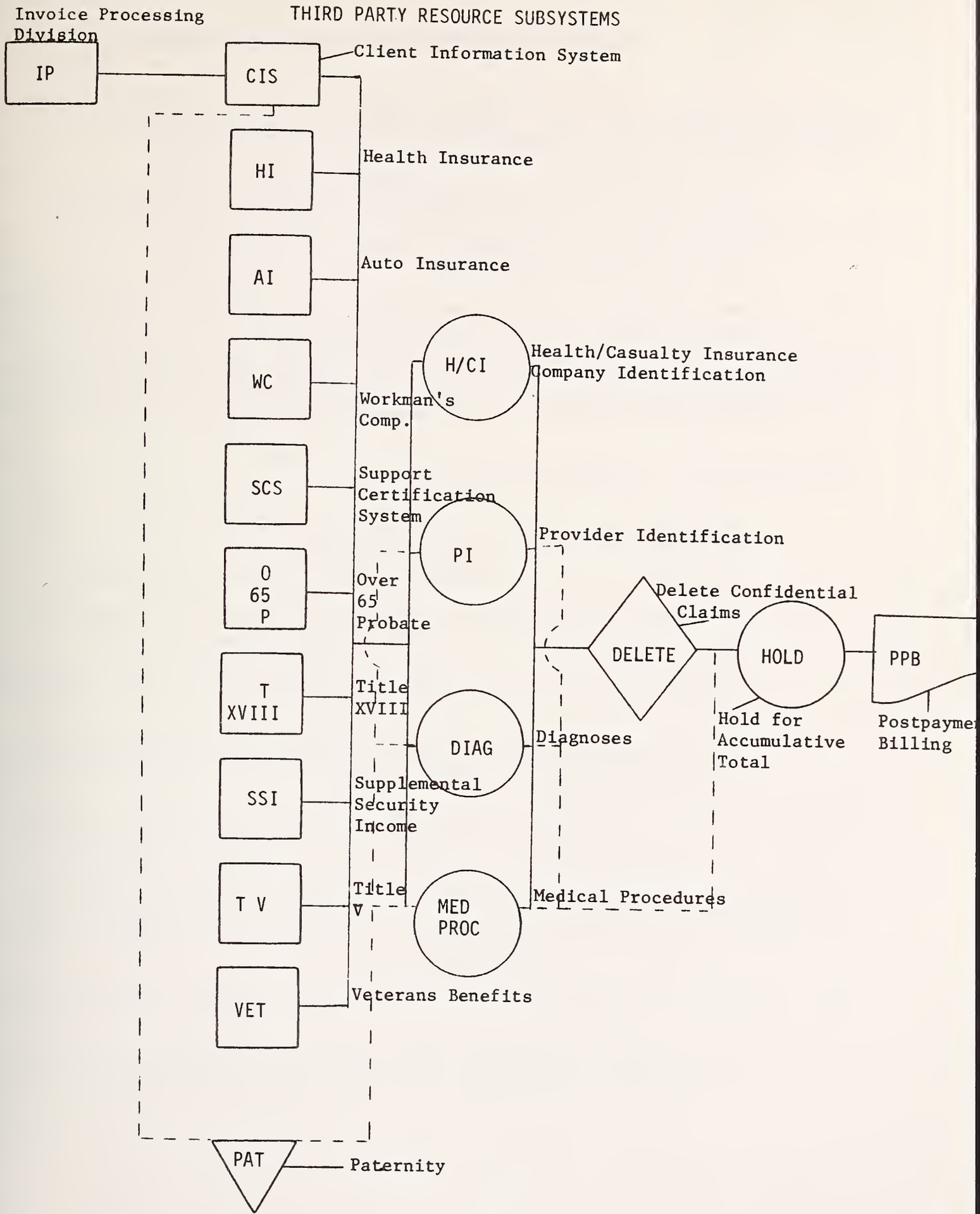
The referred-to Post-Payment Billing Form is designed to comprise identifiable data which is acceptable to the health and casualty insurance industry, private sources, and State Courts of Law, as certified documentation of Medical Assistance expenditures, for the purpose of recovering the monies expended.

By way of acknowledgement, the proposal is a partial adaptation, refinement and expansion of the State of California plan in combination with the current Michigan Client Information System.

It is realistically estimated, through extrapolation of numerical projections of valid sample studies and records of current and past experiences, that adoption and implementation of this proposal will result in minimum annual savings of $30 million dollars to the Medical Assistance program.

Enactment of Michigan's recently proposed amendatory legislation in re; Section 106 of the Social Welfare Act, Section 3109 of the Michigan "No Fault" insurance law, and relevant sections of the Michigan Workmen's Compensation Law can serve only to guarantee or substantially increase the aforementioned minimum annual $30 million dollar savings.

Attached is a flow chart of the Third Party Resource Sub-Systems.


Invoice Processing Division
THIRD PARTY RESOURCE SUBSYSTEMS
IP
CIS
Client Information System
HI
Health Insurance
AI
Auto Insurance
WC
Workman's Comp.
H/CI
Health/Casualty Insurance Company Identification
SCS
Support Certification System
PI
Provider Identification
O 65 P
Over 65 Probate
DELETE
Delete Confidential Claims
HOLD
PPB
Hold for Accumulative Total
Postpayme
Billing
T XVIII
Title XVIII
DIAG
Diagnoses
SSI
Supplemental Security Income
T V
Title V
MED PROC
Medical Procedures
VET
Veterans Benefits
PAT
Paternity

MICHIGAN'S THIRD PARTY LIABILITY PROPOSAL TO HEW

Michigan now is proposing a highly cost-effective program, as an improvement of the Medicaid Management Information System under the federal regulation (45 CFR 250.31) which requires a state plan to:

1. Take reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the plan;

2. Treat known legal liability of a third party as a resource available to welfare clients; and

3. Seek reimbursement from the resource where the resource becomes known after medical assistance has been rendered.

This means that private resources available such as health and casualty insurance must be coordinated with Medicaid funds. Medicaid, however, is clearly secondary or supplemental when private resources are available.

This "coordination of benefits" between private industry and government poses implications of considerable significance.

1. Administration must be achieved without deprivation, delay or interruption of medical services to the client; or

   unreasonable delay of payments to the providers of the services;

2. The full extent of insurance benefits available to our clients and their value was not known until we had gained some experience;

3. Potential recoveries in Michigan are now estimated at up to $30,000,000 annually;

4. The number of insurance companies and variety of insurance plans make it difficult to identify them with the client and determine the extent of their liability.

During our current fiscal year, Michigan's present manual Third Party Liability program will recover in excess of 2.8 million, at a cost-benefit ratio of 1 : 7.

After careful analysis of the successes and failures of private industry and government in coordination of benefits and subrogation, we have developed with the cooperation of the insurance industry a program which will maximize the objectives of the Third Party regulations.

Three prime requisites in maximizing the Third Party Liability Program in Michigan are necessary and underway:

1. Minor changes in applicable state laws must be effected to make them compatible with the intent of Title XIX, federal regulations and policy.

2. There must occur a total statewide commitment and ongoing dedication to identify the resources, both on the part of the Title XIX Agency staff (Department of Social Services) and the billing staff of the providers of services.

3. A cost-effective revision to the Medicaid Mangement Information System designed to increase our current capabilities by incorporating an expanded third party resource module.

Michigan's Third Party Liability Recovery System project as proposed qualifies under Section 235, Public Law 92-603 for increased federal financial support as a Medicaid Management Information System module for Third Party Liability programs and, as such, will be available to other states. The module permits realization of the full resource potential, whereas present specifications are limited to an estimated 15% of the potential recoveries.

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